August 15, 2006

Bruce Darwin Spector, Esq.
Division Counsel
Department of Banking, Insurance, Securities & Health Care Administration
Division of Health Care Administration
89 Main Street, Drawer 20
Montpelier, VT 05620-3601

Dear Bruce,

The Division of Mental Health, Vermont Department of Health is pleased to submit the enclosed Conceptual Certificate of Need Application for the Vermont State Hospital Futures Project. In this application the Department seeks permission to incur planning expenditures to analyze and compare the feasibility of various options for the replacement of the Vermont State Hospital.

The filing fee has been arranged for interdepartmental transfer on August 15. It is my understanding that BISHCA must request receipt of the fee.

Thank you for your guidance in preparing this Conceptual CON. We look forward to answering any question that you may have.

Sincerely,

Beth Tanzman
Director, Futures Project
Division of Mental Health

# The Vermont State Hospital Futures Project

# Conceptual Certificate of Need Application

*Submitted to*

**The Department of Banking, Insurance, Securities and Health Care Administration**

*Submitted by*

**The Division of Mental Health,**
**Department of Health**
**State of Vermont**

**August 15, 2006**

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A. Health Resource Allocation Plan for the State of Vermont adopted August 2, 2005 by Governor James H. Douglas pursuant to statute 18 V.S.A. 9405, Division of Health Care Administration, Department of Banking, Insurance, Securities & Health Care Administration
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**Application for Conceptual Certificate of Need**

**Applicant: Vermont Department of Health, Division of Mental Health**

**Project: Vermont Sate Hospital Futures Project**

# I. Introduction to the Futures Application

Over the past five decades, treatment of mental illness has changed profoundly, often in response to specific thresholds of new knowledge. Our health system is increasingly recognizing that general health is not, and cannot be, separated from mental health. The locus of mental health service settings has moved from restrictive, involuntary institutions to service based in the community and the treatment of acute mental illness is increasingly integrated with medical and general inpatient services. The goals of treatment have shifted from providing custodial care to the provision of active treatment and rehabilitation services to help individuals live productive lives and achieve recovery. This project seeks to move Vermont further in this direction.

## A. Project Goal

The goals of this project are to create new inpatient programs to enhance psychiatric inpatient care and replace the functions currently performed by Vermont State Hospital. In addition, this project will create new community mental health service capacities to reduce Vermont's reliance on involuntary inpatient psychiatric care. The over-all aim is to move mental health service delivery as a whole toward the vision of the transformed system and integrated system of health care services.

This application for a planning CON seeks authorization to carry out feasibility analyses of multiple options and to develop detailed plans for the most feasible models. The options will provide for inpatient psychiatric care using a primary program and/or one or more secondary programs. The preferred option under review includes developing two new levels of psychiatric inpatient care; Specialized Care and Intensive Care in the following configurations: The primary program with the preponderance of new beds would be created with Fletcher Allen Health Care (FAHC) thereby offering three levels of care at FAHC. 1) current general psychiatric inpatient care, 2) new specialized care and 3) new intensive care. The feasibility study will also assess enhancements to existing programs at Rutland Regional Medical Center (RRMC) and the Retreat Health Care for secondary programs that will provide general psychiatric inpatient care and specialized inpatient care. The options discussed in this application are the preferred scenarios developed by the Futures Project planning process, however the identified potential partners (FAHC, RRMC and the Retreat Health Care) have not yet endorsed any options pending full examination of the costs, program impact and other facility planning implications that will emerge in the Phase II CON process.

The options under review in this application are the result of multi-stakeholder study and input. While not conclusive, they have been identified as the preferred options for further study. Although this application specifically, proposes to primarily assess the preferred following configurations and plan for the arrangement(s) that emerges as the best clinical and financially feasible model, other options will be considered should they arise in the course of planning. While remaining open to alternatives, the heart of this conceptual CON , is to request permission

to incur planning expenditures to analyze and compare the feasibility of the various options for this project that are under consideration.

The primary conceptual CON question that is under review in this application is whether the Vermont Division of Mental Health should be permitted to incur planning expenditures to analyze and compare the feasibility of various options for the replacement of the Vermont State Hospital.

## B. Preferred Options for Further Analysis

Under the license of Fletcher Allen Health Care (FAHC):

1. Create a 40-bed stand alone psychiatric hospital on or off the Burlington campus.
2. Create a 40-bed program that is physically integrated with FAHC's existing inpatient services.
3. Create a 68 bed inpatient program combining FAHC's current 28-bed program with 40 new beds physically integrated with the inpatient services.

and

Under the license of Rutland Regional Medical Center (RRMC):

4. Establish 6 new psychiatric inpatient beds with the current program at Rutland Regional Medical Center via renovations and/or new construction to optimize current inpatient programming and bed capacity.

and

Under the license of Retreat Healthcare:

5. Establish the capability to provide up to four psychiatric inpatient beds at the specialized level of care at the Retreat Health Care.

If developing new capacities at Rutland Regional Medical Center or the Retreat Health Care does not prove feasible, the number of beds planned for the primary program with FAHC could be increased.

# II. Project Planning Background

## A. Overview of the Futures Project

During its 2004 session, the Vermont Legislature set in motion a strategic planning process for the future of Vermont's public mental health system. The Secretary of the Agency of Human Services was charged with creating a comprehensive plan for the delivery of services currently provided by the Vermont State Hospital (VSH), within the context of long-range planning for a comprehensive continuum of care for mental health services. To assist in accomplishing this task the Secretary was directed to establish an advisory group representing all stakeholders in Vermont's Mental Health System. This group, the Futures Advisory Committee, is to consult with the Secretary in all aspects of strategic planning.

The result of this planning process, the Vermont Mental Health Futures Plan, calls for the continued transformation of our service system towards a consumer-directed, trauma-informed,

and recovery-oriented system of mental health care. The core of the plan creates new investments in essential mental health community capacities, and reconfigures the existing 54-bed inpatient capacity at the Vermont State Hospital into a new array of inpatient, rehabilitation, and residential services for adults. This plan is consistent with Vermont's long history of establishing strong community support systems and reducing our reliance on institutional care. The fundamental goal is to support recovery for Vermonters with mental illnesses in the least restrictive and most integrated settings.

The existing Vermont State Hospital (VSH) facility is antiquated, yet the program plays a critical role in Vermont's health care system by providing involuntary inpatient care to over 200 Vermonters annually. The poor facility and high demand for the service creates challenging conditions for patients and staff every day. The Agency of Human Services seeks approval to plan to construct a new primary inpatient psychiatric care facility to replace existing capacity at the Vermont State Hospital. For a number of reasons, including its tertiary level of care capability, academic nature and willingness to partner on this Plan, The Futures Plan has identified the Fletcher Allen Health Care (FAHC) as the optimal partner to provide new, high quality inpatient services. In addition, the planning process has identified the campus in Burlington as the optimal site for a replacement facility, and accordingly, the Agency is engaged in collaborative discussions with Fletcher Allen and other stakeholders to explore the feasibility of site locations on that campus.

In addition, the Agency seeks approval to plan to develop expanded inpatient capacity through options preferred but not limited to renovation of existing facilities at Rutland Regional Medical Center and Retreat Healthcare, in partnership with those institutions.

The replacement of Vermont State Hospital (VSH) service will take place within the context of the system's transformation towards care that is more integrated with the rest of medical care, and that emphasizes reduced reliance on inpatient care.

The plan to develop new inpatient and community programs to replace the current VSH has been developed by a multi-stakeholder advisory committee that has met for over two years. The core policy considerations driving this concept are:

- Integration of psychiatric inpatient care with general inpatient care to improve clinical services and reduce the stigma and isolation currently associated with care at VSH,
- To co-locate all of Vermont's tertiary-level psychiatric inpatient care with Vermont's only tertiary hospital,
- To help insure the financial sustainability and affordability of the service by securing federal participation in the ongoing operating costs of the program, and
- To develop new community capacities to reduce Vermont's reliance on inpatient care and to further develop the infrastructure of voluntary, community treatment and support capacities.

## B. The Inpatient Planning Process and Option Analysis

### 1. Invitational Planning Meetings

In order to fulfill the dual policy imperatives for clinical service delivery integration and federal reimbursement, the Division of Mental Health has explored partnership options with Vermont's general hospitals. As a first step, all of Vermont's hospitals were invited to an information

session on August 31, 2004. Basic information about the project concepts and the current functions of VSH were offered to all hospitals. Five hospitals attended the session and expressed interest in further collaboration options. These were: FAHC, Central Vermont Hospital, Springfield Hospital, Rutland Regional Medical Center and the Retreat Health Care.

Follow-up calls were made to most of Vermont's other hospital CEOs by Deputy Commissioner of Mental Health, Dr. Susan Wehrey and Health Commissioner Paul Jarris to further solicit the interest of potential partners.

**2. The Request for Information**

This planning process culminated in a formal Request for Information (RFI) issued in mid December 2004 in which the Division described the service capacities envisioned to replace the functions of VSH and to transform the system of care (See Appendix A). The response to the RFI was overwhelmingly positive. Four of the five hospitals with psychiatric inpatient services responded as did almost all of the Designated Community Mental Health Agencies. Multiple potential partners expressed strong interest in collaborating with the Division to implement the programs and the proposed supports. [1] While the responders noted the large scope of system transformation entailed in the draft plan, the responses were creative and innovative.

It is important to note that of 14 hospitals, four responded to the RFI: Fletcher Allen Health Care, Springfield Hospital, Rutland Regional Medical Center and the Retreat Health Care. Central Vermont hospital has consistently stated that they have no plans to change or further develop their existing inpatient psychiatric program.

**3. The Impact of Federal Institutions for Mental Disease (IMD) Policy**

Because planning for replacement of services provided by VSH must consider economic impact to the General Fund, an analysis of Federal Funding impact was conducted. The Federal Medicaid Program does not reimburse care for individuals over age 21 and under age 65 in an Institution for Mental Disease (IMD). An IMD is defined as a free-standing hospital of more than 16 beds that is designed primarily for psychiatric care. In Vermont the Retreat Health Care and VSH are classified by the Centers for Medicare and Medicaid (CMS) as Institutions for Mental Disease. In 1999 Vermont negotiated, under the terms of its 1115 Medicaid waiver, an exception to the IMD payment exclusion. Beginning in 2003 the Bush administration discontinued waivers of the IMD exclusion and began the process of phasing out payments to those states with negotiated waivers. This resulted in Federal Medicaid payments for services at VSH decreasing from being 100% matched in CY 2004 to 0% Federal matching funds in CY2006. The total loss of Federal funds was approximately $7 million.

**4. The Futures Report**

Based on the RFI and the analysis of the IMD issue, the VSH Futures Report[2] offered the following specific recommendations for inpatient configurations to replace VSH. At this point, the plan called for 32 inpatient beds.

[1] (*Vermont State Hospital Futures Plan Report to Charles P. Smith, Secretary Agency of Human Services*, and State of Vermont Agency of Human Services Department of Health, Division of Mental Health, February 4, 2005
[2] Feb 4, 2005

Three possible scenarios were identified for locating the 32-36 inpatient beds providing intensive and specialized levels of care. They could all be located in one location, or in as many as three locations. The following possible configurations based on current institutional capacities and on expressions of interest in response to the RFI were identified:

- scenario 1: Thirty-two (32) beds located at Fletcher Allen Health Care.
- scenario 2: Thirty-two (32) beds located at FAHC; four additional beds could be added or reconfigured at Rutland Regional Medical Center or at Springfield Hospital.[3]
- scenario 3: Sixteen (16) beds could be located at FAHC. Sixteen (16) additional beds could be located on the campus of another hospital. 2 additional hospitals could each host additional two (2) – four (4) beds.

## 5. Secretary Charles P. Smith's Recommendation

In his report to the Vermont General Assembly (2005), AHS Secretary Charles P. Smith recommended the following inpatient configurations based on the Futures Report:

> An in-patient facility of up to Twenty-eight (28) beds, including eight (8) psychiatric intensive care unit (ICU) beds, co-located with, managed and governed by an appropriate general hospital:
>
> Four (4) additional specialized care beds located within another of the designated hospitals

Secretary Smith's proposal was met with some concern by the Futures Advisory Committee and to address this concern a special workgroup was established.

## 6. The Futures Committee Inpatient Work Group

A special work group of the Futures Committee was established to address the feasibility of and develop recommendations regarding the Secretary's proposal. This work group was comprised of Futures Advisory Committee members, representatives of all of Vermont's psychiatric inpatient programs, community mental health leaders, advocates, consumers and families. The group met three times between August and November of 2005, and additional development work occurred by email. The charge of the group was to develop a set of recommendations for the VSH Futures Advisory Committee addressing the following questions:

1. Should the in-patient program be a single site or subdivided into two or more sites?
2. Where would the unit(s) be best located?
3. Who would constitute the key partner(s)?
4. What would be the necessary components and scope for a contract with an actuarial company to prepare a report on psychiatric bed needs for Vermont?

The resulting recommendations of the work group on the inpatient setting and partner options were:

[3] The addition of four ICU beds at either of these hospitals would allow for a reduction at FAHC to 28 beds or allow an expansion of overall capacity in the system.

- The Inpatient program should be developed at a primary site and one to two smaller inpatient capacities created for geographic accessibility with close coordination, clinical collaboration, and common standards for consistency.
- The primary VSH replacement facility should not be an IMD.
- Only Designated Hospital[4] inpatient providers would be considered for the primary VSH-replacement program until such time as it is demonstrated that an agreement cannot be negotiated with one of these partners.
- Planning for the Futures project, for both inpatient and community services needs to occur in the context of considering the overall financial health of the Designated Hospital and Agency service providers.

In addition, the work group developed the following criteria for selecting potential inpatient partners.

**a. Primary Site & Partner Selection Criteria**

1. The primary VSH replacement service should not be an IMD
2. It should be attached to or near (in sight of) a tertiary / teaching hospital
3. Only designated hospital inpatient providers shall be considered for the primary VSH-replacement program until such time as it is demonstrated that an agreement cannot be negotiated with one of these partners.
4. There must be adequate space to develop or renovate a facility that will accommodate census needs.
5. The partner must agree to participate in the care management system. This assures a single standard of care, common clinical protocols, zero reject of eligible admissions etc.
6. Costs - both ongoing operations and capital construction - should be considered.
7. Outdoor activity space should be readily accessible to the units.
8. The ability to attract and retain sufficient specialty staff experienced in psychiatric care should be demonstrated.
9. The proposed partner's motivation, track record, and experience in partnering with the state and system of care should be considered.
10. Openness and past experience in including consumers/stakeholders in program design and quality monitoring should be demonstrated.
11. Willingness to participate in a public reporting of common quality standards is required.
12. Ability to deal with expedited planning time frame for full implementation to out-pace five year timeline.
13. Ability to collaborate with neighbors.
14. Ability to work closely with state and designated agency partners.

**b. Secondary Site Criteria**

In addition to the criteria for primary site and partner selection, additional criteria were identified for secondary sites.

[4] A designated hospital is a general hospital with psychiatric inpatient services that is designated by the Commissioner of Health (formerly Commissioner of Developmental and Mental Health Services) to provide treatment to individuals involuntarily committed to the Commissioner's care and custody. Currently there are 5 designated hospitals in VT: FAHC, Central Vermont Hospital, RRMC, the Windham Center in Springfield, and the Retreat Health Care.

1. Preference should be given to Designated Hospital inpatient providers until such time as it is demonstrated that an agreement cannot be negotiated with one of these partners.
2. A location consideration is to assure adequate distribution of services throughout the state.
3. Ability to provide adequate on-site medical care and demonstrated access to hospital medical services.

**7. Outcomes of this Process**

The recommendations of the Inpatient Work Group were strongly endorsed by the Futures Advisory Committee. AHS Secretary Michael K. Smith adopted the recommendations and selection criteria as the policy direction to create new inpatient programs and thereby replace the Vermont State Hospital.

The Deputy Commissioner of Mental Health consulted each of the hospitals providing psychiatric inpatient services (FAHC, RRMC, Springfield Hospital, Central Vermont Hospital and the Brattleboro Retreat) to determine their interest in partnering to provide new psychiatric inpatient services. Fletcher Allen Health Care, the Brattleboro Retreat, and Rutland Regional Medical Center all expressed interest. The only hospital that meets the selection criteria for the primary site is FAHC. RRMC and the Brattleboro Retreat meet selection criteria for secondary site. The Brattleboro Retreat is an IMD and does not have on-site integration with a general hospital inpatient program. It is, however a specialized psychiatric provider and its location offers more geographic distribution. Therefore, the concepts proposed in this application include modest use of the Retreat.

Because, as a Critical Access hospital, Springfield Hospital is limited to 10 bed "distinct part unit"[5] it cannot expand its psychiatric inpatient program. Central Vermont Hospital again declined to explore developing additional psychiatric beds.

Based on the results of this planning process and the option analysis detailed below the preliminary feasibility planning focused on FAHC to host the primary program and RRMC and Retreat Health Care for smaller capacities.

# III. Historical Summary

## A. Vermont State Hospital

The VSH is a 113-year-old institution for psychiatric care. At its height, in 1952, the average daily census was 1,350 patients. The hospital itself is a legacy of 19th century reform efforts geared toward providing more humane treatment of mental illness in a rural, retreat-like setting. As originally conceived the state hospital and its working farm were designed to provide a calm, rural, self-sustaining environment where persons suffering from severe mental illness could find respite and over time, it was hoped, regain mental stability. Before

[5] The Medicare Prescription Drug, Improvement and Modernization Act of 2003 permits Critical Access Hospitals to establish "distinct part units" (up to 10 beds) for psychiatric and rehabilitation use. These beds are excluded from the total 25 bed count limit for CAHs (Section 405, PL 108-173; Section 1820(c)(2)(E) of the Social Security Act).

modern pharmacology and psycho-social rehabilitation, relief from the stresses of daily life was the most hopeful course of treatment.

## B. Community Mental Health Movement

During the 1950's, under the leadership of Superintendent George Brooks, Vermont began the effort to develop community-based rehabilitation programs to transition patients from the Vermont State Hospital to their home communities. The core concepts of the approach were community housing, work, and peer supports. Under this initiative, many Vermonters were discharged from VSH into community rehabilitation programs. A longitudinal study conducted in the early 1980's found that most of these Vermonters had successfully integrated into their communities[6] .

In the early 1960's President John F. Kennedy called for a "bold new approach" to the delivery of mental health services, a community-based strategy that would offer an array of services responsive to different levels of disability and need, located close to where consumers live, and involving a new partnership among local, state and federal funding sources. The Community Mental Health Centers Act of 1963 caused the creation of community mental health centers. In addition, the development of psychotropic medications and psycho-social rehabilitation has also helped to bring about a dramatic reduction in reliance on institutional care. Vermont's Regionalization Plan in the late 1980's saw the development of outreach case management, supported housing, psycho-social rehabilitation programs and crisis diversion residential bed programs. Partly funded by a bridge grant from the Robert Wood Johnson Foundation, the census at Vermont State Hospital was reduced from 320 to the high 70's through the development of these community programs. In SFY 1990 (July 1989-June 1990) the resources to community agencies for services for adults with severe mental illness surpassed funding for the Vermont State Hospital. Vermont was the first state in the nation to achieve this. At present, the budget for community services for adults is well over twice the budget for inpatient hospitalization in both VSH and designated hospitals. During 1995-1996 the nursing home units at VSH were closed. Residents were placed in typical nursing homes with augmented supports.

In 1997 – 1999 the Dale Unit at VSH was closed and a series of new investments in community residential, case management and crisis bed programs was made. These community-based services facilitated the further reduction of the daily census at VSH to its present levels of 45 – 50 patients.

Many individuals with severe and persistent mental illnesses now live full lives in the community. Efforts by the disability rights and consumer movements have helped to establish the person with a psychiatric disability as a legitimate and necessary partner in the design and implementation of the mental health system. As a consequence of these historical trends, Vermont, over the past four decades has greatly reduced its inpatient capacity.

[6] Harding C, Brooks G, Ashikaga T, Strauss J, Brier A: The Vermont Longitudinal Study of Persons with Severe Mental Illness: I Methodology, Study Sample, and Overall Status 32 Years Later. American Journal of Psychiatry 144: 718-726, 1987.

## C. Integration of Services, Evidence Based Practice and the Recovery Model

The next wave of reform, recently articulated by both the World Health Organization[7] and the President's New Freedom Commission of 2003 (quoted above), emphasizes the importance of mental health to overall health, of prevention and early intervention, of having direct services and supports that are driven by those who use them, of simplifying the service system, and of ending disparities in access to care. This national movement of reform also emphasizes evidenced-based practices,[8] the recovery model,[9] and the use of technology to access mental health care and information. In addition, national mental health system reform identifies the importance of integrating substance abuse and mental health service, of understanding the prevalence of trauma, of the unique impact of trauma on people served in human service systems, and of the importance of developing supports and services that are trauma-informed and that support resilience in all individuals, families and communities.

## D. History of Financing

The financing of Vermont State Hospital has also changed since its inception. Funding for state hospitals has been, by long standing federal policy, the responsibility of states. The Centers for Medicare and Medicaid Services (CMS) will not reimburse for care in state hospitals (Institutes of Mental Disease). In the 1990's VSH was funded primarily with State General Funds. In addition, a portion of the Medicaid Disproportionate Share Funds[10] was allocated to VSH. In April of 1999, the programs serving Vermonters with severe and persistent mental illness, both inpatient and community, were folded into Vermont's 1115B Waiver, the Vermont Health Access Plan (VHAP). A capitated financial system was established which combined the financing for inpatient and community services under a single program; all of which was "matched" by Medicaid funds. Under this arrangement, Vermont negotiated a waiver of the exclusion that prevents Medicaid participation in the Vermont State Hospital, and federal funds were used to reimburse for care at VSH (see discussion section II, A, 3). At the same time, the federal Disproportionate Share Funds that had been allocated to VSH were reallocated to Vermont's community hospitals.

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[7] See World Health Organization's 2001 report on mental health.

[8] See State Health Plan for further discussion of Evidence Based Practices.

[9] Recovery has many definitions. For one expert, it means "a process of learning to approach each day's challenges, overcome our disabilities, learn skills, live independently and contribute to society" [Ruth Ralph, quoted by the *NASMHPD/NTAC* (National Association of State Mental Health Program Directors/National Technical Assistance Center) *e-Report on Recovery* Home Page, www.nasmhpd.org/spec_e-report_fall04intro.cfm *e-Report*]. For others, recovery may be "the ability to live a fulfilling and productive life despite a disability." Or it may imply "the reduction or complete remission of symptoms. . . Having hope plays an integral role in an individual's recovery." (*NASMHPD/NTAC, Achieving the Promise*, p. 5.) Stressing independence, peer support, and community-based services, the recovery concept originated in the psychiatric survivor community, many members of which had been institutionalized and were able with peer support to completely recover. They challenged the existing rehabilitation model of care, with its more modest goals of preparing individuals to work in closed workshops and live under supervision, an approach that carried with it the implication of lifelong illness, progressive disability, and ongoing need for treatment, frequently in an institution.

[10] Disproportionate Share program is a Medicaid program that allocates money to state Medicaid Authorities based on a formula of the relative poverty of a region. The funds are intended to help off-set the expenses for hospitals of patients who have no health insurance. In the mid 1990's, Disproportionate Share funds to the states were capped.

Throughout the 1980's and the 1990's as inflationary pressures caused significant increases in spending on hospital care in Vermont, the relative expenditures at Vermont State Hospital remained flat and did not keep pace with health care inflation nor with the evolving standards for inpatient care.

# IV. Current Vermont Mental Health Service System

## A. Overview

Vermont's public mental health services system is primarily funded by Medicaid and State general funds and is overseen by the Division of Mental Health, which is part of the Agency of Human Service's Department of Health. Medicaid is overseen by the Agency's Office of Vermont Health Access, commonly known as OVHA.

### 1. Statutory Authority and Responsibility of the Division of Mental Health for Provision of Services for Persons with Severe and Persistent Mental Illnesses

Pursuant to 18 V.S.A. § 7205, the department of developmental and mental health services ["DDMHS," the predecessor of DMH] operates the Vermont State Hospital. In addition to exercising the general administrative duties set forth under 3 V.S.A. §§ 3052 and 3053, the Commissioner of DDMHS is specifically empowered under 18 V.S.A. § 7401 to "designate, control and supervise the property, affairs and operation of hospitals . . . and institutions equipped and otherwise qualified to provide inpatient care and treatment for individuals who are mentally ill . . . ." 18 V.S.A. § 7401(3). The Commissioner also "supervise[s] the operation of community mental health units" and "supervise[s] the care and treatment of patients at the [Brattleboro] Retreat in the same manner and with the same authority that he supervises patients at the Vermont State Hospital." 18 V.S.A. § 7401(4), (5).

Under 18 V.S.A. § 7401(14) and (15), the Commissioner "plan[s] and coordinate[s] the development of community services" and "contract[s] with community mental health centers" to ensure the availability of services. Chapter 207 of Title 18 provides a detailed framework for the creation, operation and control of community mental health agencies. See 18 V.S.A. §§ 8901-13. Under this chapter, the Commissioner is broadly empowered to "ensure that community services to mentally ill . . . persons throughout the state are provided through designated community mental health agencies." 18 V.S.A. § 8907(a). In furtherance of this purpose, the Commissioner is required to designate public or private nonprofit agencies to provide or arrange for the provision of these services."[11]

### 2. Scope of the Mental Health System

Vermont's Public Mental Health Services system includes VSH, five designated hospitals,[12] and 11 community agencies designated[13] to provide services to adults with severe mental

[11] Id

[12] A designated hospital is a general hospital with psychiatric inpatient services that is designated by the Commissioner of Health (formerly Commissioner of Developmental and Mental Health Services) to provide treatment to individuals involuntarily committed to the Commissioner's care and custody.

[13] A designated agency is a community mental health center designated by the commissioners of health and of aging and independent living (formerly the commissioner of developmental and mental health services) as the lead agency to provide comprehensive services in a specific geographic area to Vermont's priority mental

illnesses, and children with severe emotional disturbances. The Designated Agencies (DA) are (Clara Martin Center, Counseling Service of Addison County, Health Care and Rehabilitation Services of South Eastern Vermont, Howard Center for Human Services, Lamoille County Mental Health, Northwestern Counseling and Support Services, Rutland Mental Health Service, United Counseling Service of Bennington County, Washington County Mental Health). The present application focuses on the first of these groups.

In addition there are approximately 800 individual practitioners (licensed social workers, psychologists, counselors) who participate in the Medicaid program as mental health providers. Any Vermonter may access mental health services from these practitioners. In addition, many Vermonters enrolled in Medicaid seek mental health care, often in the form of medications from their primary care physicians. Medicaid claims data indicate that primary care physicians write more prescriptions for psychotropic medications than any other group in Vermont. Finally, many individuals seek publicly funded care from hospital emergency rooms.

Also, there is a privately funded system of individual and group practices, paid for primarily through private employer-based health plans.

### 3. The Current Inpatient Services System

There are 117 licensed psychiatric inpatient beds in the state's designated hospitals (DHs) (Fletcher Allen Health Care, Central Vermont Hospital, Rutland Regional Medical Center, the Windham Center in Springfield, and Retreat Health Care) 54 beds at VSH and 12 beds at the White River Junction Veterans Hospital,[14] for a total of 183 adult psychiatric inpatient beds within the state. Vermonters also use hospital-based psychiatric services in neighboring states[15] (primarily Dartmouth Hitchcock). Within this broad capacity for inpatient care, the division of mental health (DMH) oversees a network of hospitals designated to accommodate involuntary care,[16] with patients hospitalized in locations as close as possible to their home community. These partnerships between DMH and the hospitals began in 1994 and have led to a significant shift in the number of involuntary admissions away from VSH.

Since SFY 2002, VSH average daily census has ranged from 46-48. The maximum VSH census is capped by bed capacity (54). A process for diversion back to designated hospitals and DA programs is triggered when the census approaches 50. This situation occurred approximately 30 times in the past two years.

There were 252 admissions of adults to DHs for emergency examinations in SFY 2004. In addition, there were 250 admissions of Community Rehabilitation and Treatment Programs (CRT) clients with Medicaid coverage for voluntary inpatient hospitalization in DHs and out-of-state hospitals.

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health populations: adults with severe mental illnesses, individuals with developmental disabilities, and children and youth with severe emotional disturbances.

[14] The services at the White River Junction Veterans Hospital are available only to Veterans and only on a voluntary basis.

[15] In CY 2002, Vermonters used 55,501 inpatient bed days for mental health treatment, of which 4,941 were provided in out-of-state hospitals, for an average daily census of 14 Vermonters in out-of-state hospitals. The in-state average daily census was 152 during this same period.

[16] In accordance with Vermont statutes governing the emergency examination and commitment of individuals with mental illness.

## B. Current Realities and Challenges

An unintended consequence of Vermont's emphasis on community treatment has been chronic under-funding of VSH.

Three forces led to the development of the Futures Plan to replace the Vermont State Hospital. First, recognizing the antiquated facility and the isolated nature of the program, the Division of Mental Health launched a planning process to consider options for replacing VSH. Second, beginning in 2003 the Bush administration systematically discontinued any waivers of the IMD exclusions by renegotiating the terms and conditions of 1115B and 1915C waivers as they came up for renewal. Vermont was one of roughly nine states that had exemptions under Waiver programs. This resulted in the loss of all federal funds by the end of calendar year 2005 at VSH.

The third event(s) was the decertification of Vermont State Hospital from the Centers for Medicare and Medicaid Services (CMS) in September of 2003 following two patient suicides and a series of failed inspections. The hospital briefly regained this certification and federal funding in November, 2004, but lost it again in February 2005. The facility and programming at Vermont State Hospital had been such that the program did not meet accreditation standards and the safety of patients was considered at risk.

### 1. Department of Justice Investigation

Following the decertification, the United States Department of Justice (DOJ) investigated VSH and found violations of patients' rights with the use of restraint, seclusions, and in treatment planning. In September 2004, the DOJ found that the VSH facility, and treatment services provided therein, denies patients their rights under the United States Constitution and federal statutory laws. Specifically, the DOJ cited violations of the Equal Protection clause of the Constitution and the Americans with Disabilities Act.

In the Findings Letter, dated July 5, 2005, DOJ attorneys noted,

> "the physical structure of the building is more prison-like than supportive of patient dignity and right to treatment in an environment that is conducive to treatment and recovery. While neither the Constitution nor federal statutes require any sort of bright or lush surrounding, an expert consultant's observation is worth noting:
>
> > The conditions of the physical plant . . . are dehumanizing. No one should expect individuals to achieve recovery when they have to reside in a jail-like setting, sleeping right next to their uncovered toilets and having no functional closet space for their belongings[17].

The Department of Justice also found that the clinical services at VSH violate patients' constitutional rights, stating that "the conditions and services at VSH substantially depart from generally accepted standards of care."[18] In particular, DOJ found that

> *"VSH fails to: (1) protect patients from harm and undue restraints; (2) provide adequate psychiatric and psychological services; and (3) ensure adequate*

[17] Findings Letter at 4. Document available on request.
[18] Findings Letter at 5.

*discharge planning and placement in the most integrated setting appropriate to each patient's individualized needs."*[19]

DOJ also found that VSH's risk management quality assurance systems substantially depart from professional standards of care. They note that these deficiencies expose patients to an unreasonable risk of harm. DOJ has required that

*"VSH develop and maintain an integrated system to monitor and assure quality of care across all aspects of care and treatment."*[20]

For example, VSH must create a quality assurance and risk management system that incorporates adequate methods for data capture, retrieval, and statistical analysis to identify and track trends in patient treatment. Although VSH has already made improvements in these systems, and has every intention of complying with the DOJ agreement, these changes truly require integration with a larger hospital environment. In addition to improving clinical quality, integration will allow Vermont to leverage the sophisticated data and quality assurance systems already in place at its healthcare institutions and will avoid the need to create duplicate systems.

On July 21, 2006, the United States filed suit against the State of Vermont, also naming the Governor, Secretary of the Agency of Human Services, Commissioner of Health, Deputy Commissioner of the Division of Mental Health, and Executive Director of VSH in their official capacities. In the Complaint, the DOJ asks that the federal court enjoin the State of Vermont from violating patient's rights through its operation of VSH. The DOJ and State of Vermont agreed that they would ask the court to conditionally dismiss the complaint, because Vermont has agreed, in a Memorandum of Agreement filed with the Court, to make many significant changes to the services and structure at Vermont State Hospital. If Vermont is unable to comply with the terms of the agreement, the U.S. Attorney General is empowered to ask the Court to compel the State to make the necessary changes.[21]
DOJ attorneys have informed the Division of Mental Health that some terms of the agreement may never be satisfied if the current physical structure remains unchanged.

### 2. Summary of the Summer 2006 Settlement with the Department of Justice

The State of Vermont and U.S. Department of Justice agreed to resolve the Complaint through a conditional dismissal premised on a detailed Settlement Agreement. The agreement requires that the state make specific improvements to VSH to correct conditions and practices that may violate federal statutory and constitutional laws, and agree to the appointment of two clinical experts, DOJ, Dr. Mohamed El-Saabawi and Dr. Jeffrey Geller, to monitor Vermont's compliance.

Over a four-year period, Dr. El-Saabawi and Dr. Geller, along with DOJ attorneys, will regularly assess the state's ongoing efforts to meet criteria which aim to maintain and improve the quality of the care at VSH. These criteria fall into the following areas: integrated treatment planning, mental health assessments and services, discharge planning, documentation, seclusion and restraint, emergency involuntary medication, incident management, quality improvement and environmental conditions.

[19] Id.
[20] Id.
[21] 42 U.S.C. § 1997b(a)(1).

# V. Inpatient Mental Health Needs

## A. Prevalence of Mental Disorders

The incidence of mental illness over time is stable in the population. Two large epidemiological studies conducted 10 years apart to determine the incidence and prevalence of mental illness in the American population found that the prevalence of mental disorders did not change statistically from 1993 to 2003[22]. An estimated 5 – 6% of the adult population has a *serious* mental disorder and 12-13% has a *moderately serious* disorder. Individuals with such disorders may require hospitalization for psychiatric treatment. In view of this data, Vermont can expect that the current rates of inpatient utilization for mental disorders will not diminish in the future based on reduced prevalence of mental illness in the population.

## B. Inpatient Utilization

No significant decreases in inpatient demand/ utilization are anticipated.

The recent historical rates of Vermont's per capita inpatient use for adult psychiatric care (all hospitals) show increases in the episodes of psychiatric hospitalization (from under 4,000 annually to just under 5,000); decreases in patient days overall (more than 64,000 patient days to less than 54,000 patient days annually); and increase in the number of people admitted for inpatient psychiatric care from more than 2400 to 3400.[23] Table 1 shows the total psychiatric inpatient services provided to Vermonters over 10 years.

[22]Ronald C. Kessler, et al. *Prevalence and Treatment of Mental Disorders, 1900 – 2003*, New England Journal of Medicine, June 16, 2005

[23] The State of Vermont does not have unique client identifiers across service providers. For this reason, Probabilistic Population Estimation has been used to provide unduplicated counts of people served (with 95% confidence intervals). Actual person counts are available for Retreat Health Care and the Vermont State Hospital.

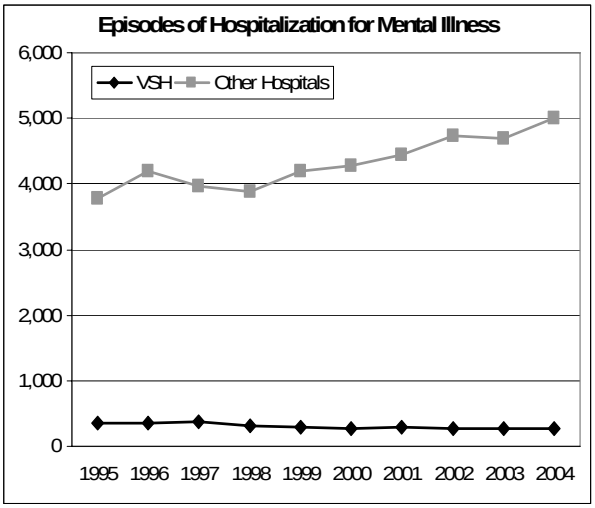
**Table 1**
**Total Inpatient Services for Mental Illness Provided to Vermont Residents: CY1995-2004**

| | | | | Total | |
|---|---|---|---|---|---|
| | Episodes of Hosp. | Patient Days | Avg. LOS | Unduplicated # of People Served ** | |
| 1995 | 3,769 | 64,711 | 17 | 2,489 | ± 17 |
| 1996 | 4,185 | 62,123 | 15 | 2,688 | ± 18 |
| 1997 | 3,975 | 57,342 | 14 | 2,569 | ± 18 |
| 1998 | 3,887 | 50,795 | 13 | 2,576 | ± 18 |
| 1999 | 4,190 | 52,921 | 13 | 2,772 | ± 19 |
| 2000 | 4,276 | 50,534 | 12 | 2,922 | ± 20 |
| 2001 | 4,435 | 54,262 | 12 | 3,041 | ± 21 |
| 2002 | 4,737 | 55,501 | 12 | 3,302 | ± 23 |
| 2003 | 4,701 | 54,429 | 12 | 3,227 | ± 22 |
| 2004 | 4,998 | 53,693 | 11 | 3,409 | ± 24 |

Division of Mental Health -Vermont Department of Health 2006

The following three graphs also show the information about episodes, patient days, and individuals hospitalized over 10 years.

Graph 1 shows the episodes of hospitalization for Vermonters over 10 years at VSH and all other hospitals.

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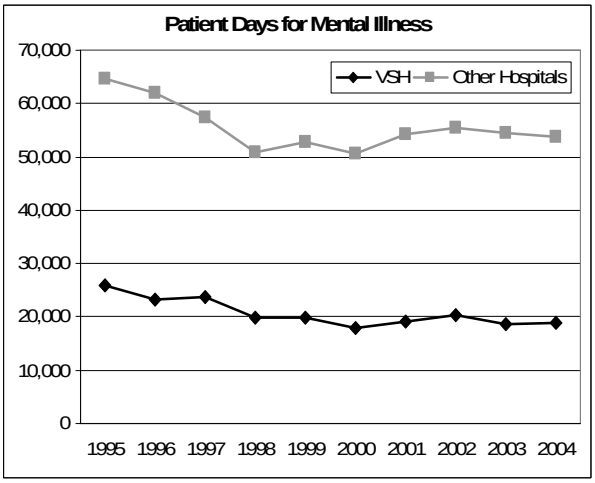
Graph 2 shows patient days for Vermonters over 10 years at VSH and all other hospitals

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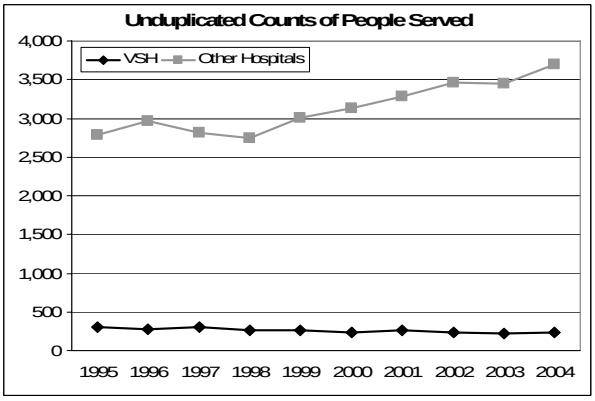
Graph 3 shows the unduplicated counts of Vermonters served over 10 years at VSH and all other hospitals




Division of Mental Health – Vermont Department of Health 2006

Based on historical utilization trends; Vermont's use of psychiatric inpatient care is not expected to decline in the future.

In 2005, the Department of Health engaged Milliman, Inc. to conduct an actuarial study of the needed bed capacity for adult mental health inpatient services by 2016 (See Appendix B). This actuarial study projects a small increase, approximately 1% per year in the demand for inpatient services in the future based on population and service utilization trends.

The utilization at the Vermont State Hospital has been consistent for the past 10 years. As the Table below indicates, from 1997 to 2006, VSH has served at minimum 200 admissions a year and provided over 18,000 bed days of care for all years except in SF Year 2000.

**Table 2**
**VSH Admissions & Bed Days**
**1997 - 2006**

| SFYear | Admissions | Bed Days |
|---|---|---|
| 1997 | 302 | 24,156 |
| 1998 | 304 | 21,150 |
| 1999 | 224 | 18,794 |
| 2000 | 224 | 17,675 |
| 2001 | 221 | 19,230 |
| 2002 | 240 | 19,718 |
| 2003 | 216 | 19,256 |
| 2004 | 219 | 18,963 |
| 2005 | 200 | 18,951 |
| 2006 | 215 | 18,755 |

Division of Mental Health - Vermont Department of Health 2006

## C. Vermont State Hospital Population

VSH is the only hospital in the system that has a no-reject admission policy. This means that Vermont State Hospital never refuses a clinically eligible admission. It also accepts transfers from all of the psychiatric inpatient units in the state when the needs of a given patient exceed their programmatic and staffing capabilities. As such, VSH serves a unique safety net purpose in Vermont's overall system of care and, historically has provided care to individuals with higher acuity, greater risk for dangerous behavior, longer term stays and/or who require involuntary medications under ACT 114.[24]

Based upon the state's responsibility for individuals in its custody, there are several categories under which an individual may be admitted to VSH: (1) A person who is assessed to be a danger to self or others and is not able to be served by a less restrictive alternative than secure inpatient care (an Emergency Exam); (2) a person charged with a criminal act who has psychiatric symptoms demonstrating a need for inpatient psychiatric care as well as an evaluation for legal competency; (3) a person found not guilty of a crime by reason of insanity, and in need of inpatient psychiatric care; and (4) Persons in the custody of the Department of Corrections and in prison, whose psychiatric acuity require inpatient care. The

[24] Act 114 sets out the legal process and implementation procedures for the provision of non-emergency involuntary psychiatric medications.

later three categories are often generally termed "forensic" admissions. Most forensic admissions are for a person charged with a crime who needs inpatient level care.

The state provides this inpatient care primarily through VSH. In the 1990's, it began an effort to provide some of the inpatient psychiatric care for individuals who were being treated involuntarily closer to their home counties and in more integrated medical settings, by designating private psychiatric units to receive such patients as well. However, VSH remains the primary facility for involuntary care, including being the "safety net" that must accept all patients who cannot be accommodated in the designated hospital system.

In the current system, all Emergency Examinations (EEs)[25] are first proposed for admission to DHs, and if these hospitals are unable to admit, the patient is referred to VSH. Therefore, all EE admissions to VSH have been refused by DHs. This represents between 84 and 115 admissions per year. The most frequent reasons cited by DHs for refusing proposed EE admissions are "the patient's behavior" or that admitting the patient would render the "acuity of the unit" too high to safely manage. The DMH and the DHs have specifically agreed that, in the current system, DHs have the option to decline an admission they do not feel they can safely manage.

In 2005 the Vermont General Assembly amended the statutes regarding inpatient forensic evaluations to include other hospitals beside VSH. The Division of Mental Health has developed new procedures in collaboration with inpatient partners to provide hospital treatment services for individuals referred by the courts for evaluation who meet medical necessity criteria for psychiatric inpatient treatment. FAHC, RRMC, and the Retreat Health Care can now all admit individuals in need for psychiatric inpatient care on forensic legal status.

It is not feasible to simply close the current program at VSH and expect that the other inpatient psychiatric programs could absorb the patients within current levels of service capacity. *VSH provides a critical and unique level of care that must be replaced in the system*

Table 3 shows a 10-year history of the admissions to VSH and their legal status. While VSH is distinguished from other psychiatric inpatient programs by its focus on involuntary care, if other options were available, it is likely that some of the care currently delivered at VSH on an involuntary status could be provided in alternative programs on a voluntary basis. Vermont has an important opportunity to plan for replacement services that are voluntary.

**Table 3**
**Vermont State Hospital Admissions Legal Status**
**Fiscal Years 1995 – 2004**

[25] Admissions for Emergency Examinations (EE) occur upon written application by an interested party (usually the DA screener), accompanied by a certificate signed by a physician who is not the applicant. The application sets forth facts and circumstances that indicate the need for an emergency examination according to the following standards: the person must have mental illness, be in need of treatment, and be dangerous to self or others, and it must be the case that no less-restrictive alternative is sufficient.

| Fiscal Year | Total Admissions | Voluntary Admissions[26] | | Emergency Admissions | | Forensic Admissions | | Other Admissions[27] | |
|---|---|---|---|---|---|---|---|---|---|
| 2004 | 219 | 13 | 6% | 95 | 43% | 103 | 47% | 8 | 4% |
| 2003 | 216 | 16 | 7% | 84 | 39% | 104 | 48% | 12 | 6% |
| 2002 | 240 | 14 | 6% | 115 | 48% | 97 | 40% | 14 | 6% |
| 2001 | 221 | 8 | 4% | 100 | 45% | 106 | 48% | 7 | 3% |
| 2000 | 224 | 10 | 4% | 114 | 51% | 84 | 38% | 16 | 7% |
| 1999 | 224 | 5 | 2% | 90 | 40% | 115 | 51% | 15 | 7% |
| 1998 | 304 | 6 | 2% | 161 | 53% | 122 | 40% | 15 | 5% |
| 1997 | 302 | 11 | 4% | 152 | 50% | 115 | 38% | 24 | 8% |
| 1996 | 289 | 3 | 1% | 178 | 62% | 86 | 30% | 22 | 7% |
| 1995 | 313 | 9 | 3% | 189 | 60% | 95 | 30% | 20 | 7% |

Division of Mental Health - Vermont Department of Health 2006

In addition to VSH's being primarily a site for involuntary treatment, very few of the patients served at VSH have private health insurance. In SFY 04, only 4 percent of the total bed days (17,051) were supported by third party insurance and 31 percent of the bed days had no source of payment.

The relative strength of the community services infrastructure directly impacts the use of psychiatric inpatient care. Assuming that the community services system is sustained, and that the new community resources proposed in the Futures plan are implemented, the independent actuarial analysis indicated that Vermont would need between 41 - 65 inpatient beds to replace VSH[28].

## D. Facility Considerations

As the VSH downsized, there was commensurate growth in the community-based programs. Funds previously used to support the hospital were matched with money from the federal Medicaid program to support these programs. These community services and supports have continued to grow, assisting almost all individuals who experience mental illness to lead full, productive lives in the community. By the late 1990s, as the Dean Administration worked to close the Dale Unit[29] at VSH, a significant investment in new, voluntary community services was made once again. Between 2000 and 2004, the average daily in-house census at VSH stabilized at 45-50.

### 1. Current Environment

[26] Infrequently patients are admitted to VSH on a voluntary basis. This is typically part of an specific treatment plan for an individual who is frequently hospitalized.

[27] "Other" admissions are all involuntary and refer to revocation of conditional release, revocation of orders of non-hospitalization and inter-state transfers

[28] Milliman

[29] The Dale unit did not directly serve admissions; rather, long-stay VSH patients were transferred to the program after many months in the hospital.

Even in the face of continuing investments in renovation, the VSH facility in Waterbury is antiquated. The buildings are old and the rooms narrow, with poor heating and ventilation systems. All units are cramped and there are no comfortable places for family visiting, program activities or physical activity. The space for patients to meet with professional staff, or for individual counseling, for instance, is also inadequate. There are no quiet areas designed for patients who want time alone, away from others who are agitated, loud, or in other ways disruptive. There is little natural lighting in rooms or hallways, and the hallways are too narrow to allow for the transfer of restrained patients on regular beds; bath and toilet facilities are not available in the rooms, but are in one location with multiple toilets and showers. A list of specific deficits includes but may not be limited to the following:

1. Bedrooms no longer meet footage required.
2. Seclusion rooms do not meet current standards that include anterooms and attached bathrooms.
3. Two tiny rooms are available on Brooks[30] 1 & Brooks 2 for family visiting, provider visits, physician, and social worker contacts.
4. There are no visiting rooms on Brooks except the dining room & clinical treatment room.
5. Therapeutic group activities, treatment team meetings, and overflow from family and provider visiting occur in the dining rooms on all three floors.
6. The units are dark and the patient day rooms are cramped.
7. There is no real opportunity for acutely ill or highly agitated patients to go elsewhere on the units - the walking space is extremely limited.
8. The hospital's single-hall design of each unit does not allow for walking to occur with uninterrupted flow - many new facilities have patient care areas that wraparound thus allowing patients to circulate and have a reduced sense of confinement. This can be particularly important for individuals with dementia or Traumatic Brain Injury (TBI) for whom walking is one of the few activities possible.
9. There is no educational or training space on the units.
10. The line of sight for nursing staff is impeded by building layout thus additional staff are required for observation of patients.
11. There are multiple points of uncontrolled access to the hospital.
12. Yard space is limited with few real exercise opportunities.
13. VSH clinical offices are in separate locations from the Hospital building which does not assist in the team work among disciplines and greater appreciation of the on-going dynamics in the patient milieu.
14. VSH administration is in separate housing from hospital building needlessly removing managers from the hospital and the patient care environment.
15. VSH shares a campus with many different functions that are unrelated to a medical treatment environment. There is no sense of a general purpose of activities within the campus.
16. VSH is supported by a volunteer ambulance association whose local hospital (Central Vermont Hospital) is a not a tertiary care facility.

## 2. Current Renovations at VSH

[30] The Brooks Building in the Waterbury State Hospital Complex houses the State Hospital. The Dale unit was replaced by the Current Brooks Rehabilitation Unit on the ground floor renovated for this purpose after the Department of Corrections took over the Dale Building.

The State continues to upgrade the facility at VSH while working towards implementing the Futures Plan. The Brooks building renovations project began shortly after the de-certification of the Vermont State Hospital. The Department of Buildings and General Services (BGS) surveyed the building to identify potential patient safety hazards, and established the scope of work required to renovate inpatient rooms and create separate spaces where patients could safely be apart from the noisy, active units. In SFY 04 BGS provided approximately $100,000 for renovations designed to improve patient safety.

The following year, SFY '05, additional funds were appropriated to design and construct special treatment units. The design was started, but it became apparent the work would substantially exceed the appropriated funds. An alternate proposal was presented to and approved by the Mental Health Oversight Committee to address patient services and enhancements, including repair of porches, installation of air conditioning, development of seclusion and quiet rooms, and creating shelters in the yard for patient use. Additional safety concerns were also identified and for FY 06 the legislature appropriated another $300,000, to address these concerns. This work was completed with the addition of supplemental funds from BGS of approximately $150,000

Another safety audit was commissioned by the Vermont State Hospital using outside consultants. As a result of this audit, the legislature appropriated $100,000 in the SFY '07 Capital Bill to address identified patient safety concerns as well as patient management improvements and environmental enhancements. The work is ongoing with the priority focus on safety concerns, followed by the patient management improvements and then environmental enhancements. Work is approximately 60% complete for the safety issues and it appears funds are still available to remedy the most of the patient management issues. BGS is planning to implement them as quickly as funds allow.

However, these are at best a stop-gap measures since the isolated nature and design of the facility itself does not meet current standards for a therapeutic environment. The Architect's Report below illustrates the problem.

### 3. Architect's Findings and Recommendations from Facility Inspection

In February of 2006 Gary L. Graham, FAIA and Carroll A. Ockert, LFACHE were engaged to conduct an inspection of the Brooks Building at VSH. The objective of the inspection was to assess the physical setting of the three units at VSH to determine their consistency with the standards of care for similar psychiatric facilities in the United States. This involved a thorough inspection of all program spaces and representative patient accommodations on every unit. The Report cites specific items for improvement while clearly stating that the over-all environment of the hospital does not meet current therapeutic standards.

**Selected examples of the non-therapeutic environment:**

> The Brooks Building has the capacity to house 54 psychiatric patients within three units on its three floors. … The building was built in an era that had little interest in creating a therapeutic environment that would be conducive to humane treatment. It utilizes institutional materials and construction methods throughout. The resulting setting does not represent the current standards of architectural practice in today's environment of healthcare facility design. … However, relative to safety and security, the Brooks

Building provides patients with a remarkably safe, albeit unpleasant physical environment.

Brooks 1 is accessed from a corridor that acts as a "sally port" vestibule, with a security office, and controlled visitor rooms. The initial impression of the unit is reminiscent of a "corrections" facility instead of a therapeutic behavioral healthcare facility. This impression is reinforced by a "chain link" partition and door at the end of the corridor, at the point of entry onto the unit. Recommendation: Replace the chain link partition with a hollow metal and glass partition similar to the access to the Rehab Unit.

Patient Bedrooms do not meet the current standards for size and appointments. The porch side bedrooms have the corrections style stainless steel toilet in the bedroom, which is contrary to current standards that typically will have a private bathroom connected to each patient bedroom. Recommendation: We do not see a remedy to this situation without dramatic renovations to the entire building which would not be practical.

Patient Bathrooms are accessed down long corridors, providing a control problem and areas for patient hiding places: Recommendation: We do not see a remedy to this situation without dramatic renovations to this area.

Seclusion Room does not meet the current standard that includes a vestibule and dedicated toilet. There is no remedy to this situation without dramatic renovations.

**Conclusion**

The facility was designed almost seventy years ago for the purpose of housing psychiatric patients. There is evidence throughout the facility that the hospital is aware of, and concerned with safety, security and control issues. The observations and recommendations that we have made are to address isolated problem areas, and aspects of the building that might have escaped the notice of competent and diligent staff. … We believe that if the recommendations are implemented, the hospital will improve the physical structure and diminish the potential of patients causing harm to themselves and others. We understand that these are short-term remedies that will, of necessity, be supplemented with a long term solution that will address the essential need to create a humane and therapeutic environment which is not possible in the Brooks Building.[31]

## E. Clinical Considerations

The setting and operation of the state hospital as a stand alone program has resulted in an institutional culture characterized by isolation and separation from community mental health and general hospital services. By definition such an isolated design is contrary to contemporary standards that call for integration of a continuum of services from crisis response to inpatient services, and after-care programming involving an array of support services. Furthermore, the recovery model of care requires the active involvement of peer programming and supports through out the process. Such a system requires full integration of services consistent with the concept of care in the least restrictive environment that safety

[31] From the Report of the Architect's inspection of the Vermont State Hospital, Psychiatric Facility Safety and Security Review Based on an Inspection that took place on February 21, 2006, Gary L. Graham, FAIA, Carroll A. Ockert, LFACHE

protections permit. The structure and isolation of VSH, even upgraded to the highest level possible, will not meet this standard. In addition, the culture created by an isolated facility also limits the opportunities for professionals to interact with their peers and stay current with emerging treatment trends across the continuum of care.

Increasingly, the patients admitted to VSH have complex medical conditions requiring treatment. As a stand-alone facility, miles away from any other hospital program, it is not feasible for VSH to provide the same level of medical diagnostic and treatment services that any other inpatient Vermonter care experiences.

**Medical Conditions of Patients Served at VSH**

The isolation of VSH leads to a continued lack of timely access to appropriate medical care for individuals with co-occurring medical conditions who are hospitalized there. The following data on VSH patient needs from August 1999 through August 2000 illustrates the medical treatment needs of such patients. Among the 266 individuals hospitalized at VSH, there was an average of 3 major, medical diagnoses per patient that required active treatment. During the course of the year there were 210 patient visits to outside medical facilities. Some 3,000 lab tests were ordered. There were 27 patient trips to a medical hospital emergency room. During the year approximately 16 – 20% of the patient population were classified as having a medical illness considered high risk. An additional 30% had a serious medical illness. Individuals in the high risk group included: (1) an individual with insulin dependent diabetes with neuropathy; (2) an individual with severe Chronic Obstructive Pulmonary Disease (COPD) who was oxygen dependent; (3) a woman with breast cancer, chronic hypertension and COPD; (4) a young woman with diabetes; (5) an older man with profound brain damage from Traumatic Brain Injury; (6) an individual with profound dementia and metastatic colon cancer; and, (7) a woman with severe lung disease. Among those with serious medical problems were: (1) an underweight, severely diabetic individual; (2) an individual prone to grand mal seizures; (3) an older woman with alcoholic dementia; (4) an individual with impacted wisdom teeth; (5) several severely obese individuals with high cholesterol; and (6) an individual with medical after-effects from severe self starvation. As this data illustrates, many VSH patients require on-going treatment for other serious health conditions. The distance between VSH and the nearest general hospitals, and the lack of linkage to readily available specialty care, result in patients with co-occurring medical conditions being chronically medically underserved.

The population served at VSH is not static, and the needs of individuals fluctuate over the course of hospitalization.

The level of care required, the length of stay and the degree to which patient behaviors present the risk of dangerousness means the provision of services for this population is generally longer and of greater intensity than the care provided in a general psychiatric unit. The population includes individuals with traumatic brain injuries (TBI) and other brain injuries, individuals with co-occurring substance abuse disorders, individuals with mental illness and developmental disorders. The services proposed in this plan need to be clinically and programmatically capable of serving individuals with multiple diagnoses. The rate of co-occurring conditions among VSH patients is very high. Substance abuse was identified as a factor in 60 percent of the admissions in SFY 04 and complex health conditions abound. Equally important is the expected extremely high rate of patients with significant trauma histories. VSH does not systematically collect data on trauma but the National Trauma Consortium estimates that as many as 80 percent of men and women in psychiatric hospitals

have experienced physical or sexual abuse, most as children. This is particularly of concern in an involuntary treatment program in which the very factors that contribute to resilience and healing: choice, control, informed consent, collaboration and the sharing of power, are often undermined. Screening for trauma should become a priority throughout the system in the immediate future.

In keeping with the nature of the population it serves, two intensive levels of care are provided at VSH that are not currently available elsewhere in the system: Specialized Inpatient Units (SIPs) and Intensive Care Units (ICUs). Following is a brief description of the requirements of these services.

Specialized Inpatient Units (SIPs)

At present, only Vermont State Hospital is able to meet the needs of individuals who require specialized inpatient care. These individuals are admitted directly from the community, referred by the courts for observation, or are transferred from the designated hospitals. They share the following characteristics:

- almost exclusively admitted on an involuntary basis,
- refuse medication and often other forms of treatment,
- likely have diagnoses of schizophrenia or other psychotic disorder,
- have, on average, lengths of stay greater than 30 days.[32]

The characteristics of a specialized inpatient unit include both staffing and architectural attributes. The staffing pattern includes:

- Higher RN to patient ratios (one nurse to four patients) than may be found in designated hospital psychiatric units.
- Psychiatrically trained direct care staff (registered nurses and psychiatric technicians or mental health workers) whose core competencies include:
    - assessing and reducing suicide risk
    - assessing and reducing risk of aggression
    - non-aggressive, humane interventions in the management of violent behavior
    - participation in the creation of individualized plans of care that are trauma-informed and recovery-centered
    - preventing seclusion and restraint
    - using and teaching recovery methods, including the creation of individualized crisis plans
    - employing motivational interviewing techniques
    - implementing behavioral plans

- Psychiatrists with special expertise in forensics, the care of persons with serious mental illness, substance abuse, recovery methods, and trauma care.

[32] In the context of the diagnostic categories, patients with thought disorders have the longest average stay when at VSH. The hospital overall average in 2003 was for 19 percent of patients to be discharged within a week, 39 percent within two weeks, and 80 percent by the end of three months. Those with schizophrenia and other psychoses were discharged at a rate of only 9 percent within one week and 20 percent within two weeks (half the average rate). At the end of three months, 29 percent were still hospitalized. This was highest percentage of all categories, with the next closest at 19 percent.

In addition, specialized inpatient level of care must have easy access to general medical care. Finally, SIP programs should have ready access to specialty consultations from psychology, neuropsychiatry, and other disciplines.

The physical characteristics of a specialized inpatient service must be optimized for safety, and include single rooms, adequate space to allow for physical activity and exercise, and quiet areas to facilitate voluntary regaining of control of one's behavior.

Intensive care units (ICU). This more enhanced version of a specialized unit provides acute, stabilizing care and allows for maximum containment of patients most at risk of violence to self and others. This physical capacity does not currently exist at VSH; individuals with this level of need are managed by increased staffing (1:1 or 2:1 staff to patient ratios) and at present are more likely to require emergency involuntary interventions such as seclusion and restraint to prevent harm to self and others.

The main distinguishing features of the ICU would be: size, configuration of physical space, monitoring capacity, higher registered nurse-to-patient ratios, and a staff with an enhanced skill set and experience.

In order to be responsive to the needed patients who have experienced trauma, the SIP and ICU programs will be required to implement the core elements of a trauma informed treatment system including a continuous review of the programs' policies and practices to assure that these do not replicate trauma dynamics for patients and staff.

As a stand-alone hospital, the treatment for the conditions described above, requires complex transport by ambulance or sheriff. In State fiscal year 2005; the Waterbury ambulance responded 22 times to emergent and emerging medical needs of patients at VSH. In State fiscal year 2006 the Waterbury ambulance responded 31 times. These numbers are consistent with prior years.

Vermont's community and inpatient mental health providers, including its community hospitals, meanwhile, rely on VSH as a safety net and currently lack the clinical and physical security capacity to provide the VSH level of care.

## F. Financial Considerations

A shift in Medicaid policy lends urgency to the need for reform. As discussed earlier, the federal Medicaid program does not reimburse care for individuals over the age of 21 years and under the age of 65 in an Institute for Mental Disease (IMD). The VSH is one of two Vermont facilities[33] classified by CMS as an IMD. In addition, the federal government rescinded the 1115B waiver of the IMD exclusion beginning in calendar year (CY) 2005.

In SFY[34] 04, the operating cost for VSH was $13,520,510. The projected Medicaid receipts, through the 1115B waiver for SFY 04 was $7,045,510.[35] The scheduled phase out of the exception under the 1115B waiver combined with the decertification caused the loss of federal funds. Consequently the entire operating budget of Vermont State Hospital, $18

[33] Retreat HealthCare in Brattleboro is Vermont's other IMD.

[34] The State Fiscal Year (SFY) runs from July 1 to June 30th and is therefore different from the calendar year.

[35] The de-certification of VSH in SFY 04 prevented Vermont from realizing these receipts; however, with recertification, these receipts can now be claimed through the phase out period described above.

million for SFY 2007, is supported by State General Funds. Continued facility renovations are costly and since the results do not and will not meet requirements for a quality program, continued renovation funding is wasteful.

## G. Staffing Considerations

Planning the development of new inpatient services at locations other than the current VSH creates a climate of uncertainty for the staff at Vermont State Hospital. Yet even as the system is in transition, the current program must continue operating and making improvements to the fullest extent possible. It is also clear that the workforce at Vermont State Hospital is uniquely qualified, by virtue of experience and training, to provide specialized and intensive psychiatric inpatient services in the future. Recognizing the importance of this skilled workforce to Vermonters, a Futures Advisory Committee work group has met nine times in recent months to develop a hierarchy of preferred scenarios to transition the current workforce to the new programs envisioned in the Futures Plan. In addition, this group is identifying the specific conditions necessary for any of these scenarios to be successful.

## H. Conclusion

This analysis of need for VSH replacement considered the following issues: prevalence of mental illness, utilization of psychiatric inpatient care, actuarial findings, legal services, the unique role that VSH plays in the services system, limitations of the current facility and funding options. Based on these, the Futures Plan concludes that the capacity at VSH needs to be replaced with new inpatient and community programs that are responsive to current and future needs of Vermonters in need of mental health service.

The current program functions and the physical plant at VSH must be replaced. The new inpatient programs must accomplish VSH's historic role of providing tertiary psychiatric inpatient care, must improve clinical treatment services including access to medical care, and end the isolation of the program from the rest of the inpatient care system.

# VI. Vision for the Future

## A. Vermont State Hospital Replacement

The vision of this project is to create a health system that fully integrates the provision of mental health with other health services such that Vermonters hospitalized for acute psychiatric inpatient care have access to the same diagnostic and treatment facilities as all other Vermonters. Stigma is eliminated and individuals who suffer serious and persistent mental illness have appropriate recovery services.

The planning for replacement of the functions currently performed at VSH is taking place at a time of unprecedented change in the delivery of Vermont's social services. The Agency of Human Services is in the middle of a four-year effort to transform its role in the delivery of services. One reorganization outcome was the dissolution of the Department of Developmental and Mental Health Services and the relocation of the Division of Mental Health within the Department of Health. This change reflects the State's commitment to and

endorsement of an approach to mental health treatment and care, which within the continuum of care embraces the public health philosophy of public education, prevention, early intervention, as well as care and treatment and recovery. In addition it recognizes the importance of addressing mental health issues to enable Vermonters to lead healthy lives within healthy communities. Public health efforts focus on assisting individuals and communities to acquire the knowledge and skills they need to thrive. With respect to the mental health system, this requires continued support for the social, housing, employment and recovery education components of treatment and care.

By acknowledging that mental health is essential to overall health and by providing better integration of mental health, substance abuse, and health care services,[36] we hope to reduce the stigma often associated with mental illness, [37] and further advance the quest for full equity and parity.

The goals then that this project hopes to advance include:

- Increasing citizen's access to the services and healthcare that they want and need;
- Improving program quality and consumer satisfaction;
- Designing programs and services that are consumer and family driven;
- Insuring programs are responsive, sustainable and efficient over time;
- Improving the health and integration of citizens with disabilities in their home communities.

## B. Consistency with Vermont's Health Resources Allocation Plan (HRAP) and Vermont State Health Plan

### 1. Health Resource Allocation Plan

The Health Resource Allocation Plan (HRAP) itself is organized to integrate mental health services throughout all levels of care--- emergency services, inpatient services, outpatient services and community services. The HRAP endorses the Futures Plan and strongly emphasizes the importance of clinical integration. Continued integration of mental illness diagnosis and treatment with the diagnosis and treatment of all other illnesses is a fundamental direction for mental illness care embraced by Vermonters both in the *Health Resource Allocation Plan* and the *Vermont State Health Plan*. Specifically the recommendations in the *Health Resource Allocation Plan* calls for the State to:

- Implement the Futures Report recommendations as the foundation for determining future mental health and substance abuse inpatient planning.[38]

[36] See Appendix 1 for a description of two Department of Health Initiatives.

[37] Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma is widespread in the United States and other Western nations. Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders - especially severe disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care. Responding to stigma, people with mental health problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment.

[38] Health Resource Allocation Plan for the State of Vermont (HRAP) Recommendations, Inpatient, Emergency & Hospital-Based Services, Inpatient Services, Recommendation 5, p xi.

- Support implementation of the broad recommendations in the Vermont State Hospital Futures Plan, including
    i. Ensuring an adequate number of beds to provide essential core services, including
        1. Inpatient beds at an appropriate general hospital (preferably an academic medical center),
        2. Intensive care beds at another hospital,
        3. Sub-acute beds in one to three locations,
        4. A secure residential facility, and
        5. Additional diversion beds in two or three locations.
    ii. Locating services in or near the most appropriate setting: academic medical centers, community hospitals, or other community-based facilities.
    iii. Constructing new facilities when existing facilities are inadequate to meet the standard of care required for the service.
    iv. Including a thorough clinical and operational planning process that includes the State's hospitals.[39]

In addition the HRAP provides a number of specific criteria to be addressed in constructing the system. See Part Three (3) below for a detailed description of how the proposed Futures Project is consistent with the Health Resource Allocation Plan section four CON Standards (HRAP Criterion 1). In addition, the Hospital Community Needs Assessments specifically identified mental health and substance abuse services as service gaps in all hospital service areas. [40]

**2. Vermont State Health Plan**

*The Vermont State Health Plan* (VSHP) calls for action to

> "fully integrate the treatment of severe and persistent mental illness with the Vermont Blueprint for Health. This integration must include informed decision-making systems for individuals and families…, enhanced self-management and peer support services…, commitment to and further development of community-based care, supporting the most integrated … and least restrictive alternatives for care through a full range of community-based treatment and support options."[41]

The project described in this Conceptual CON application will allow planning for services that will provide support these policy directives by physically locating inpatient mental health services with medical services, thereby enhancing the integration of care.

Additionally, although not reviewed in this application, the full Futures Plan will provide the community-based, continuum of services required to support persons with severe and persistent mental illness such that they can function to their maximum capacity in their home communities. This project establishes the infrastructure needed for full implementation of the Futures Plan.

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[39] HRAP Recommendations, Mental Health / Substance Abuse Services, Recommendation 1, p xii.
[40] HRAP, Community Needs Assessment xli
[41] Vermont State Health Plan, 2005, p. 91

### 3. The Key Components of the Futures Plan

The primary goal for this project --- supported by the granting of a Conceptual CON to proceed--- fundamentally acts in accord with the calls to action described in HRAP and VSHP.

The Plan includes[42]:

(a) new inpatient capacity for intensive care and specialized care (the subject of this CON application);
(b) the provision of new, residential recovery and secure residential treatment programs;
(c) the provision of crisis beds for stabilization and diversion;
(d) a care management program to coordinate access across the system;
(e) peer services, transportation, supportive housing, and legal services; and
(f) enhancement and sustainment of existing delivery system elements:
    (1) the designated agency structure
    (2) strengthening of existing community based peer support services
    (3) enhanced adult out-patient services
    (4) expansion of the co-occurring disorders project
    (5) provision of public health prevention and education strategies
    (6) provision of offender out-patient services
    (7) implementation of the mental health plan for Corrections, and finally
    (8) maintenance of VSH services during the transition of the system.

## C. Call to Action

### 1. Initial Legislative Action

As earlier noted, during its 2004 session, the Legislature set in motion a strategic planning process for the future of Vermont's public mental health system. The Secretary of Human Services was charged with creating a comprehensive plan for the delivery of services currently provided by the Vermont State Hospital (VSH), within the context of long-range planning for a comprehensive continuum of care for mental health services. To accomplish this, the Secretary was directed to establish an advisory group whose membership would represent all stakeholders in Vermont's mental health system and to consult with this group on all aspects of the strategic planning.[43] The legislation[44] gave the Secretary and the advisory group nine guiding principles to direct its planning effort. The Secretary directed the Division of Mental Health (DMH) to work with the advisory group to help frame this plan, an outline of which was presented to the Legislature's Mental Health Oversight Committee on October 15, 2004 and a final report in February 2005. Also in February 2005 the Secretary of the Agency of Human Services presented a report to the Vermont Legislature.

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[42] The Vermont Mental Health Futures Plan Proposal to Transform and Sustain a Comprehensive Continuum of Care for Adults with Mental Illness, Presented to the Legislative Mental Health Oversight Committee, March 22, 2006, The Agency of Human Services, Department of Health Division of Mental Health, Approved by the Committee, April 25, 2006).

[43] In June, 2004, the previously existing Vermont State Hospital Advisory Group accepted the secretary's request to serve as the designated state hospital future planning advisory group, pursuant to last spring's legislation.

[44] House Bill 768 Section 141a (the "Big Bill").

## 2. Secretary Charles P. Smith's Report

In his Report *Recommendations For the Future of Services Provided at the Vermont State Hospital* [45], Secretary of the Agency of Human Services, Charles P. Smith, stated:

> "We continue to struggle with long-standing, systemic problems at VSH. Under exceedingly difficult circumstances, staff and management achieved recertification last year, only to lose it again this month. Overall, a convergence of events and forces has clearly shown that aspects of Vermont's mental health system of care need serious improvement. These events and forces include:
>
> - Suicides at VSH and the subsequent decertification,
> - More recent safety and security breaches that resulted in a second decertification,
> - Suicides and other deaths in the prison system,
> - A decision[46] by the federal government to terminate funding for "institutes of mental disease" (IMDs) including VSH,
> - An investigation by the U.S. Department of Justice with respect to civil rights issues at VSH,
> - Wide recognition that the VSH premises are antiquated and cannot be considered a suitable therapeutic setting for recovery from mental illness, and
> - An increasing number of patients with co-occurring substance use disorders.
>
> It is also clear that services are not well coordinated across the continuum of mental health care, from primary care providers to the community partners, to the designated hospitals, to the VSH and prisons; that many services, especially in the adult out-patient and substance abuse categories, are bottle-necked at the community level; that opportunities for effective early intervention are being missed; and that many Vermonters in need are not receiving services. Further, it is clear that the community mental health system has faced increasing demands for service, with limited funds allocated for cost of living and inflationary pressures."

## 3. Futures Plan Recommendations

### a. Secretary Charles P. Smith's Proposed System Components

Secretary Smith went on to offer several recommendations based on the Futures Plan. These included developing:

- New inpatient programs at a primary and secondary location to be operated under the license of host hospital(s) (32 beds)
- New community residential programs (22 beds) to replace the long term rehabilitation service of the VSH
- New community crisis stabilization (10 beds) to reduce admissions to VSH and other hospitals

[45] February 4, 2005, Charles P. Smith

[46] This decision applies to all IMDs and was not prompted by any problems at VSH.

- Peer services
- Housing
- Outpatient Mental Health Services
- Care Management system
- Transportation
- Legal Services
- Augmented Prison-Based Services

**b. Legislative Recommendations**

In the spring of 2005 the General Assembly passed the following motion in the Big Bill, Appropriations Sec113e:

(a) The general assembly adopts the principles in the May 31, 2005 draft report from the department of health for restructuring the delivery of mental health services currently received in the Vermont state hospital, including the following:

1. The current state hospital facility should be replaced with a facility or facilities with fewer than 54 beds and with meaningful programmatic integration of medical and community mental health services.
2. As the replacement occurs, the operations and human resources in the state hospital should be supported and enhanced to ensure safety, and the clinical programming should effectively support recovery.

3. The capacity and network of community support services should be expanded to meet patient needs in a clinically appropriate manner consistent with system values.

**c. Futures Advisory Committee Recommendations Approved by the Oversight Committees**

Throughout the summer and fall of 2005 and the winter of 2006, the Futures Advisory Committee and a series of committee working groups met to refine the inpatient and community portions of the Futures Plan. Based on this work, the Joint Mental Health Legislative Oversight Committee and the Joint Fiscal Committee approved the plan as described below.

**i. Overview of the Transformed System: The Futures Plan**

The Vermont Mental Health Futures Plan calls for the transformation of our service system towards a consumer-directed, trauma-informed, and recovery-oriented system of mental health. When fully implemented, the plan will transform inpatient and recovery services for the most severely ill and will improve coordination of services and increase capacity for all adults with mental illnesses. The result will be a continuum of care in which

- The individual is actively engaged in their own recovery.
- Prevention, early intervention and alternatives to more acute levels of care are pursued aggressively.
- Peer supports are expanded and recognized as essential to recovery.
- All the elements are coordinated.

This plan is consistent with Vermont's long history of establishing strong community support systems and reducing our reliance on institutional care. The fundamental goal is to support recovery for Vermonters with mental illnesses in the least restrictive and most integrated settings.

The replacement of Vermont State Hospital (VSH) services is proposed to take place within the context of the system's transformation towards care that is more integrated with the rest of medical care, and that emphasizes reduced reliance on inpatient care.

The core of the plan is the proposal for new investments in the essential community capacities, along with reconfiguration of the existing 54-bed inpatient capacity at VSH into a new array of inpatient, rehabilitation, and residential services for adults.

**ii. New Inpatient Capacity for Intensive Care and Specialized Care**

Two new levels of inpatient care, "intensive care" and "specialized care," are proposed, reflecting more intensive staffing patterns than currently exist at VSH or in Designated Hospital psychiatric inpatient programs. These new levels of care each would be configured with high staff-to-patient ratios, flexibly scalable environments, and specialized clinical programming. The intensive care service is planned for stabilization of individuals with the most dangerous behaviors. The specialized care service will offer staff-intensive programming, and the longer lengths of stay required by individuals with particularly severe or unresponsive symptoms. The plan proposes to create 40 new inpatient beds comprised of intensive care and specialized care beds.

The new inpatient programs would be created in three locations.

- A new facility is proposed to be built located at or adjacent to a hospital, preferably a tertiary level, academic medical center (Fletcher Allen Health Care). This program would provide both new levels of inpatient care, intensive care and specialized care.
- Retreat Healthcare and Rutland Regional Medical Center have indicated their willingness to explore how to enhance their capacity to develop specialized inpatient care programs. This would assist geographic access to specialized inpatient care and would provide the entire system with needed surge capacity.

**iii. New Residential Recovery and Secure Residential Treatment Programs**

The plan proposes to create two new programs designed to meet the needs of a longer-term care population currently served at VSH but who do not need inpatient-level care. These programs are residential recovery programs for sub-acute rehabilitation, with a capacity of eighteen (18), and secure residential treatment, with a capacity of six (6).

The ***residential recovery programs*** are designed to meet the needs of individuals who have experienced repeated hospitalizations or extended stays at VSH. These individuals often have a slow response to treatment and multiple disabling conditions. With individually focused rehabilitation programming in non-institutional settings, this population is believed to be capable of making significant gains towards recovery. The current VSH environment, while very caring and supportive, is fundamentally institutional. As such, it constitutes a very difficult environment for engagement in the building of adequate recovery skills to successfully maintain recovery in a less-structured setting.

***Secure residential treatment programs*** will be designed to meet the needs of individuals whose symptoms are sufficiently stable to no longer need inpatient care, but who are legally restricted from discharge from a secure setting.

### iv. Crisis Beds for Stabilization and Diversion

The plan proposes to augment the existing network of **crisis beds** for stabilization of an individual's crisis within a community setting and diversion from hospitalization. The goal is to develop programs to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization. The plan includes developing an additional capacity for ten (10) new crisis beds, based on a statewide assessment of gaps in the crisis intervention system.

### v. Care Management

The Futures plan includes a ***Care Management Program*** to ensure the management and coordination of access to high-intensity services so that Vermonters have access to the appropriate level of care and the system's resources are used efficiently. The system will help to ensure that the most integrated and least restrictive care consistent with safety is being delivered. The care management function will provide service coordination for individuals who cross multiple departmental, institutional and/or mental health program services. This coordination requires the development of common clinical protocols among all partners (designated agencies, diversion providers, designated hospitals, Corrections, etc.), the ability to convey common information for clinical services, utilization management oversight, quality improvement and conflict resolution. The care management system will create a service network that coordinates the following components:

- General hospital psychiatric inpatient beds.
- Specialized care psychiatric inpatient beds.
- Intensive care psychiatric beds.
- 18 existing mental health crisis beds.
- 10 new crisis diversion / triage beds.
- Access to the new adult outpatient capacity, for community reintegration.
- Inpatient, residential and outpatient substance abuse treatment services.

### vi. Peer Services, Transportation, Supportive Housing, and Legal Services

The Futures Plan proposes new ***Peer Programming***. These services offer effective, recovery-oriented supports. The plan will create new peer support programs targeted to individuals who use VSH. Peers also will be an integral part of the provision of traditional and new services. The expansion of stand-alone peer services will also to be explored.

The plan provides resources to create secure, alternative ***Transportation*** options to the current system of using sheriffs. Additional resources for ***Transportation*** costs may be necessary as the Futures plan is implemented, due to the geographical distribution of programs.

The plan proposes new ***Supportive Housing*** resources. The lack of decent, affordable housing has been consistently identified by the Futures Advisory Group as one of the most significant unmet needs of Vermont's citizens with mental illness. There is broad consensus in the stakeholder community of providers, advocates, family members and consumers that

safe and adequate housing is crucial to reducing hospitalization and supporting recovery. Therefore, housing supports will be expanded under the plan.

With inpatient hospital beds distributed in more than one location, this plan identifies the need for additional resources for ***Legal services,*** due to the need for attorneys to consult with clients and witnesses in multiple locations.

**vii. Additional Enhancements Proposed by Secretary Charles P. Smith and Supported by the Futures Advisory Committee**

The context for planning the replacement of the services at Vermont State Hospital is the entire mental health service system. The Futures Advisory Group, the Legislative Mental Health Oversight Committee, and then-AHS Secretary Charles P. Smith have viewed the successful implementation of the Futures Plan as contingent upon sustaining and enhancing the overall services system.

- **Sustaining Community Infrastructure**

Planning for the Futures Project, for both inpatient and community services, needs to occur in the context of considering the overall financial health of the designated hospital and agency service providers. The plan assumes continuation of adequate resources to sustain all existing services, including caseload growth.

- **Enhancing Community Infrastructure**

Fundamental to the plan is the recognition that a smaller, replacement inpatient unit, even with the addition of other residential programs, cannot succeed in meeting the needs of the population that VSH currently serves without enhancing the existing community mental health services infrastructure. This requires the transformation of community based and peer services into a voluntary and upstream system of supports and services that ultimately reduces Vermont's reliance on psychiatric inpatient care and involuntary care. These services need to respond to the practical needs of citizens and be appropriately dispersed geographically. In addition, this continuum of supports and services will be recovery-oriented and trauma informed.

Then-Secretary Charles P. Smith's report to the legislature recommended developing and/or enhancing the following services.

- **Adult Outpatient Services**

Secretary Smith's report to the Legislature proposed new capacity for the community mental health agencies and / or private providers to provide adult out-patient service. Several different program approaches were described. These included replication of the Health Care & Rehabilitation Services of Southeastern Vermont (HCRS) program for cost-effective management of pre-CRT (Community Rehabilitation and Treatment) individuals; collaboration with the Department of Children and Families to intervene with specific TANF (Temporary Assistance for Needy Families) families on issues of depression and substance abuse; or integration of mental health care into primary care settings such as federally qualified health centers.

- **Expansion of the Co-Occurring Disorders Project**

This is a successful collaboration between the Department of Corrections and the Department of Health divisions of Mental Health and of Alcohol and Drug Abuse Programs. The two existing programs, with teams in Burlington and Brattleboro, use an evidence-based integrated mental health and substance abuse treatment approach to provide outpatient treatment to severely ill and addicted offenders. These teams combine Corrections' field staff, mental health clinicians, and substance abuse clinicians. Clients are seen daily in the community or in group treatment. Results show a markedly reduced risk of re-offense, reduction in hospital care, and positive recovery results. Additional teams are needed in Rutland and Barre.

- **Public Health Prevention and Education Strategies**

With the reorganization of the Agency of Human Services, the divisions of Mental Health, of Alcohol and Drug Abuse Programs, and of Community Public Health are now together within the Department of Health. This creates a special opportunity to apply public health, population-based prevention and early intervention techniques to the field of mental disease and substance abuse. New resources are needed to craft and communicate the public health, early intervention message with respect to mental illness. We will continue and expand on work presently being done with primary care physicians and their staffs on diagnosing and treating depression, and on making referrals to appropriate specialized services. This work will benefit from coordination with Vermont's chronic care initiative, the Blueprint for Health.

- **Offender Out-Patient Services & Mental Health Plan for Corrections**

The current capacity for the community mental health agencies and / or private providers to serve the mental health and substance abuse needs of selected offenders who are returning to the community following incarceration is widely viewed as inadequate. The development of specific mental health and substance abuse programs targeted to this population may help reduce recidivism and increase the employment and general community participation of this group. Priority will be given to interventions with a high potential of supporting the offender's long-term success.

The Futures plan builds on ongoing efforts to implement phase-in of the Corrections plan submitted by the Secretary on February 4, 2005 under the Futures legislation.

### 4. The Current Program at Vermont State Hospital

Operations at the current VSH will continue until the new program capacities described in the Futures plan can be implemented. As community capacities come on line, the bed capacity at the VSH can begin to shrink. However, due to the need to enhance the current VSH staffing levels, significant staff reductions are not anticipated. The investments made now in the staff and resources at the current VSH, along with the psychiatric services being provided by Fletcher Allen Health Care, will assist in a seamless transition towards an excellent, state-of-the-art psychiatric inpatient service in the future. VSH has established a strategic plan to implement the specific recommendations made in a review by Fletcher Allen Health Care. This plan has been updated to include the requirements of the Department of Justice, licensing conditions by the Vermont Board of Health, and meeting certification requirements under CMS or Joint Commission for the Accreditation of Healthcare Organizations.

### 5. The Continued Planning Process

The Futures Advisory Committee will continue to be the lead multi-stakeholder group providing feedback and advice on the planning and implementation of the full Futures project. This committee is advisory to the Secretary of the Agency of Human Services and is staffed by the (DMH). The Futures Advisory Committee membership represents the advocate, consumer, family, provider, and labor interests of the mental health community. This committee fulfills the legislative intent regarding the importance of broad stakeholder involvement in the Futures project. It is against the backdrop of the transformed system described above: The Futures Plan – that the Department of Mental Health seeks approval for inpatient care planning within this Conceptual CON.

## D. Inpatient Partner Option Analysis

Within the scope of the overall policy framework established by the Futures Advisory Committee, the General Assembly, and the Douglas Administration, an analysis of the options for inpatient partners was conducted using the following considerations:

- Identification of which inpatient programs could add new psychiatric beds
- Consideration of costs including the IMD issue
- Interest of the potential partner(s) to provide specialized inpatient psychiatric care
- Feasibility of program development including experience, ability to attract and retain staff, and necessary critical mass to develop a strong program.

### 1. Critical Access Hospital Designation Limitation

The first consideration in identifying which of Vermont's 14 acute care hospitals could add significant psychiatric bed capacity (10 + beds) to replace existing VSH beds is whether the hospital is a Critical Access Hospital and thus limited to a total of 25 acute care and 10 "distinct part" specialized beds. Currently eight (8) Vermont hospitals are Critical Access Hospitals:

- Copley Hospital
- Gifford Medical Center
- Grace Cottage Hospital
- Mt. Ascutney Hospital and Health Center

- North Country Health System
- Northeastern Vermont Regional Hospital
- Porter Medical Center
- Windham Center in Springfield.

Springfield Hospital already has a 10-bed psychiatric program so can expand no further. In principle, the seven other critical access hospitals could each develop a 10-bed psychiatric program. These hospitals have expressed little or no interest in developing a new 10-bed psychiatric program at the specialized or intensive level care needed to replace VSH. Northeastern Vermont Regional Hospital could potentially be interested in developing a general psychiatric inpatient program as a way to better serve their community and to assist in the recruitment and retention of needed specialty staff for other services including outpatient psychiatric care. However, they have indicated no interest in operating VSH replacement inpatient services[47]. It would realistically be difficult for these hospitals to develop the depth of programming and staffing required to serve the patient population from VSH and to do so at the relatively small scale of 10 beds.

## 2. Vermont's Community Hospitals

This leaves 6 general hospitals as potential candidates to add psychiatric beds to replace VSH bed capacity: Brattleboro Memorial Hospital, Central Vermont Medical Center, Fletcher Allen Health Care, Northwestern Medical Center, Rutland Regional Medical Center and Southwestern Vermont Health Care. The Table below provides information on staffed bed capacity for these hospitals.

Vermont's Community Hospitals (non-critical access)

**Table 4**
**Staffed Bed Capacity: Community Hospital Inpatient Beds – 2005**

| Hospital | Staffed Psych Beds | Total Acute Care Staffed Beds |
|---|---|---|
| Brattleboro Memorial Hospital | 0 | 47 |
| Central Vermont Medical Center | 15 | 94 |
| Fletcher Allen Health Care | 28 | 430 |
| Northwestern Medical Center | 0 | 70 |
| Rutland Regional Medical Ctr | 19 | 104 |
| Southwestern VT Health Care | 0 | 80 |

Source: Health Resource Allocation Plan, Section Three, Chapter 1, Inpatient Services, Table 1: Community Hospital Inpatient Beds 2005, p 7.

Three of the hospitals currently have licensed staff psychiatric bed capacity: Central Vermont, FAHC, and RRMC. It is important to note here that only four hospitals responded to the 2004 RFI: Fletcher Allen Health Care, Springfield Hospital, Rutland Regional Medical Center and the Retreat Healthcare. Central Vermont Hospital has consistently stated that they have no plans to change or further develop their existing inpatient psychiatric program.

The consideration of expressed interest aside, given their total acute care staffed beds, it is important to determine which of the 6 hospitals would be viable candidates to increase their psychiatric bed capacity. It is here that the overall total licensed acute care bed capacity and

[47] Personal communication Paul Bengtson, Administrator

average daily census potentially create risk of triggering exclusion of Medicaid payments for psychiatric services when new psychiatric beds are added to the facility.

### 3. The Institution for Mental Diseases (IMD's) Trigger

a. The IMD and Provider-Based Considerations

Two mutually exclusive, but often confused, federal regulations exist which relate to options for relocating inpatient services provided at VSH as outlined in the Vermont State Hospital Futures Plan. These regulations guide:

I. Federal Medicaid payments to *Institutions for Mental Diseases* (IMD's)
II. Organizational configurations that general hospital psychiatric units must attain *Provider-Based Status* by CMS for the purpose of receiving Medicaid and Medicare payments for inpatient psychiatric care.

Both regulations are important with respect to Vermont's need to identify VSH alternatives consistent with the policy framework established by the Futures Advisory Committee, the General Assembly and the Administration. The important policy consideration related to the inpatient portion of the Futures Plan agreed upon by the VSH Futures Advisory Committee is:

- Provide inpatient services in a manner consistent with Vermont's policy of integrating mental health and general health care services so that hospitalized individuals can have their psychiatric as well as physical health needs met in or near a tertiary care hospital

- Ensure the economic viability of inpatient psychiatric services by maximizing the potential for Medicaid payment (specifically federal financial participation) for the psychiatric inpatient care of adults between the ages of 21 and 65.

b. Exclusion of Medicaid Payments for Institutions for Mental Disease (IMD)

Since its enactment in 1965, federal Medicaid law has excluded from Federal Financial Participation (FFP) payments for Institutions for Mental Disease[48] such as the Vermont State Hospital. This "*Medicaid IMD exclusion*" prohibits Medicaid payments to IMD's for services provided to individuals between the ages of 21 and 65. An Institution for Mental Disease is defined as

> "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental disease, including medical attention, nursing care and related services"[49].

The Centers for Medicare and Medicaid Services (CMS) has specific regulatory criteria for determining if a facility is an IMD. If any of these is met, the facility is most likely an IMD in the eyes of CMS. These criteria appear in 42 CFR § 4390.C.2 and can be summarized as follows:

1. The facility is licensed as a psychiatric facility

[48] 42 U.S.C. § 1396d
[49] 42 U.S.C. § 1396d(i)

2. The facility is accredited as a psychiatric facility
3. The facility is under the jurisdiction of the State's mental health authority
4. The facility specializes in psychiatric/psychological care
5. The current need for institutionalization for more than 50% of all patients in the facility results from mental disease

Medicaid does *not* exclude payments for individuals hospitalized in psychiatric units within general hospitals provided that "the current need for institutionalization of more than 50% of all patients does not result from mental disease".

In spite of the *"Medicaid IMD Exclusion",* Vermont has historically pursued creative options for maximizing federal financial participation for costs of inpatient care at VSH. A chronology of these options and other key policy changes that have affected them follows:

- In 1995, Vermont applied and was approved for participation in an federal 1115B Waiver, which allowed the state flexibility regarding the use of federal funds in terms of the population to be served and the services that would be reimbursed. The waiver enabled Vermont to develop its VHAP program for the provision of government-financed health services to a population of low-income Vermonters who would otherwise be uninsured.

- As part of the 1115B waiver, Vermont negotiated a *"waiver of IMD exclusion"* which enabled it to develop a capitated payment system for community and inpatient services for adults with severe and persistent mental illness (referred to in Vermont as CRT consumers, or recipients of Community Rehabilitation and Treatment services). As a result of this *waiver of IMD exclusion,* Medicaid funds could be used to pay for a portion of the costs associated with treating CRT consumers hospitalized at the Vermont State Hospital.

- Beginning in calendar year 2003, the Federal government rescinded all *waivers of IMD exclusion,* thus precluding all Medicaid payments to VSH beginning in 2006. This loss of Medicaid revenue for VSH was not related to the two CMS decertifications. Rather, it represents a federal policy shift that will result in the loss of millions of federal dollars in Medicaid payments for inpatient psychiatric services at VSH (because it is an IMD). Medicaid payments for inpatient psychiatric care at general hospitals were *not* affected by this policy change because they are not classified by CMS as IMDs.

- Vermont has recently negotiated another Medicaid waiver that will allow the state great flexibility in the manner in which it organizes and pays for Medicaid services for all Vermonters. This 5-year demonstration waiver, called the *Global Commitment to Health,* might, in theory, allow the state to resume the use of federal Medicaid funds to pay for services in an IMD. Because of the need to close VSH due to the inadequacy of the physical plant and a myriad of other reasons, Vermont is faced with finding an alternative (or several alternatives) to that facility. The terms and conditions of the Global Commitment waiver will need to be renegotiated in 5 years, and it is unlikely that CMS will allow Medicaid payments in an IMD for the period following September 2010. Because of this, it would be imprudent for Vermont to build another IMD and risk future loss of Medicaid funds. Building an IMD that is not contiguous to a general hospital would also compromise the principle of simultaneous access to psychiatric and physical health care.

The receipt of federal Medicaid funds is essential to the economic viability of a system of inpatient treatment for adults with severe and persistent mental illness. Vermont's quest for alternatives to VSH must avoid the creation of a facility that would be vulnerable to the exclusion of Medicaid payments in the future. The obvious alternative to the creation of an IMD would be locating the new inpatient unit in, near, or as a satellite of, an existing general hospital. Such an arrangement, often referred to as *"provider-based status"* offers distinct advantages but it is subject to CMS regulations that define the conditions under which a unit can be deemed *"provider-based"* and receive Medicaid and Medicare payments.

c. Provider-Based Status

The CMS criteria and procedures for determining whether a facility or organization is *provider-based* are set out in 42 CFR § 413.65. If Vermont chooses to pursue the option of locating inpatient alternatives to VSH in a host general hospital (also referred to as the main provider), it would be necessary for the new or expanded psychiatric unit or facility to conform to these criteria *as well as* avoid being deemed a free-standing IMD by CMS under 42 CFR § 4390.C.2 as discussed above.

The CMS general requirements for determining *provider-based status* relate both to facilities that are *on-campus* as well as those that are satellites, or *off-campus,* as defined below. The requirements generally require that the unit or facility be integrated with and clearly part of the main provider and not be an organizational artifact created to maximize federal reimbursement. A summary of the general requirements follows:

- Licensure: the proposed provider and the main provider must be operated under the same license, except where the State requires a separate license
- Clinical Services: the clinical services of the proposed unit and the host hospital must be integrated as defined in the regulations
- Financial Integration: The financial operations of the facility or unit must be fully integrated within the financial system of the main provider, as evidenced by shared income and expenses.
- Public Awareness: The facility organization seeking provider-based status is held out to the public and other payers as part of the host provider.

In addition to the general requirements that must be met to attain *Provider-based Status*, CMS also defines *on-campus* and *off-campus* facilities and specifies the physical and organizational criteria that apply to each for the purpose of determining if either is provider-based. *On-campus* is defined as the physical area immediately adjacent to the host provider's main buildings, and other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings.

In order to be considered an o*ff-campus* facility, the unit must conform to the following:

- The *off-campus* facility or organization seeking provider-based status must be operated under the ownership and control of the main provider
- The reporting relationships between the *off-campus* facility or organization seeking provider-based status and the main provider must have the same frequency, intensity and level of accountability that exists in the relationship between the main provider and one of its existing departments

- The *off-campus* facility or organization must be located within a 35-mile radius (straight line) of the main provider with limited exceptions set out in the regulations.
- A facility operating under a management contract with the host facility must also meet these *of-campus* requirements

Any future proposals for alternatives to VSH inpatient psychiatric services must involve a thorough legal review of the regulations summarized above as they apply to specific alternative organizational arrangements. This review will occur in Phase II of the CON process.

d. Financial Significance of IMD Risk

Public payers (Medicare, Medicaid, and State General Funds) are the major source of funding for Vermont's mental health services. As the table illustrates[50], 97% of the revenues for the Vermont State Hospital are realized from Medicare, Medicaid and General Fund payments. Public funds also support approximately 60% of mental health inpatient services provided by Vermont's community and tertiary care hospitals. Some 28% of this amount is paid by Medicaid. It is this dependence on public sources that creates the significance of the IMD risk for Vermont's smaller hospitals that might choose to expand their psychiatric services. Should they do so and trigger the IMD exclusion, they risk losing Medicaid payments for all Medicaid funded psychiatric services.

[50] Milliman, p 15

**Table 5**

| State of Vermont, Department of Health<br>Payer Mix by Hospital<br>Percentage of Inpatient Days 2000 – 2005 | | | |
|---|---|---|---|
| **Payer** | **Vermont State Hospital[1]** | **Other Vermont Hospitals** | **New Hampshire Hospitals** |
| Medicare | 29% | 33% | 40% |
| Medicaid | 4% | 28% | 22% |
| State General Fund | 64% | 0% | 0% |
| Commercial Insurance | 1% | 19% | 32% |
| Self Pay | 0% | 4% | 6% |
| Free Care | 0% | 2% | 0% |
| Other | 2% | 14% | 0% |
| [1] Payer mix opportunity is impacted by Medicaid waivers and limited by decertification. | | | |

e. Data Indicating Risk of Triggering the IMD Exclusion

The hospital becomes categorized as an Institution for Mental Diseases when 50% of its daily acute care census (ADC) is generated by patients who have a mental illness as the primary diagnosis. Utilization trend data suggests which hospitals might be at risk. See Table 6 below. Note, diagnosis information at discharge is generally considered to be more reflective of treatment rendered than are admitting diagnoses.

## Table 6
## 1995-2004 Average Daily Census (ADC) for Selected Vermont Hospitals by Discharge Type (Mental Health Versus All)

**All discharge group includes all major diagnostic categories (MDCs), excluding newborns (MDC 15)**

**Mental health (MH) discharge group includes all those in Major Diagnostic Category (MDC) 19, except those classified in Diagnosis Related Group (DRG) 429, Organic Disturbances and Mental Retardation**

**ADC for Mental Health Discharges, All Ages**

| Hospital | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|---|---|---|---|---|
| Brattleboro | 0.2 | 0.3 | 0.1 | 0.2 | 0.1 | 0.2 | 0.0 | 0.2 | 0.1 | 0.1 |
| Central VT | 8.4 | 11.3 | 14.8 | 9.4 | 9.6 | 7.5 | 8.3 | 10.5 | 9.5 | 10.2 |
| FAHC | 22.0 | 21.7 | 22.7 | 20.5 | 22.0 | 19.1 | 19.3 | 18.3 | 21.2 | 19.8 |
| Northwestern | 0.0 | 0.1 | 0.1 | 0.1 | 0.0 | 0.1 | 0.1 | 0.1 | 0.1 | 0.0 |
| Rutland | 6.2 | 5.3 | 4.3 | 5.4 | 6.3 | 6.7 | 8.0 | 9.4 | 8.1 | 7.1 |
| Southwestern | 3.6 | 2.7 | 1.2 | 0.1 | 0.2 | 0.1 | 0.2 | 0.1 | 0.1 | 0.2 |
| Springfield | 5.5 | 5.4 | 7.0 | 8.5 | 11.0 | 9.7 | 10.6 | 11.9 | 12.7 | 12.7 |
| Total | 45.9 | 46.7 | 50.1 | 44.2 | 49.2 | 43.4 | 46.6 | 50.5 | 51.9 | 50.1 |

**ADC for All Discharges, All Ages**

| Hospital | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|---|---|---|---|---|
| Brattleboro | 33.2 | 32.0 | 29.1 | 26.3 | 27.8 | 25.8 | 26.2 | 26.0 | 24.7 | 22.5 |
| Central VT | 57.4 | 55.5 | 51.9 | 40.5 | 43.6 | 41.7 | 43.1 | 44.5 | 39.3 | 38.2 |
| FAHC | 360.8 | 324.4 | 303.2 | 304.1 | 326.6 | 333.5 | 330.5 | 324.4 | 312.6 | 295.0 |
| Northwestern | 35.0 | 30.4 | 21.8 | 22.7 | 20.8 | 22.9 | 22.4 | 24.7 | 24.4 | 21.8 |
| Rutland | 107.3 | 102.4 | 89.2 | 80.0 | 84.0 | 87.0 | 86.7 | 80.6 | 85.3 | 86.9 |
| Southwestern | 62.2 | 57.4 | 47.2 | 45.6 | 45.7 | 48.3 | 51.0 | 48.6 | 47.9 | 44.9 |
| Springfield | 30.6 | 28.8 | 27.4 | 27.1 | 31.5 | 31.7 | 32.7 | 31.6 | 32.2 | 32.5 |
| Total | 686.5 | 630.9 | 569.7 | 546.4 | 580.1 | 590.9 | 592.6 | 580.4 | 566.5 | 541.8 |

**ADC for All Discharges Excluding Mental Health and Newborns, All Ages**

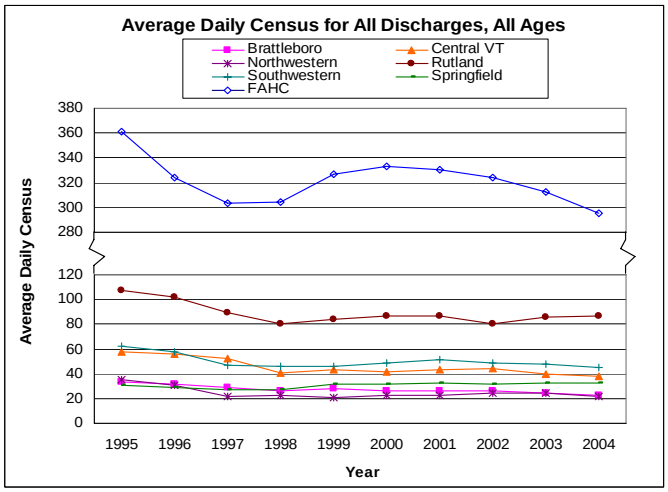
| Hospital | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|---|---|---|---|---|
| Brattleboro | 33.0 | 31.8 | 29.0 | 26.2 | 27.7 | 25.6 | 26.2 | 25.9 | 24.6 | 22.4 |
| Central VT | 49.0 | 44.3 | 37.1 | 31.1 | 34.0 | 34.3 | 34.8 | 34.0 | 29.8 | 28.0 |
| FAHC | 338.8 | 302.7 | 280.5 | 283.6 | 304.6 | 314.4 | 311.2 | 306.1 | 291.4 | 275.1 |
| Northwestern | 34.9 | 30.3 | 21.7 | 22.6 | 20.8 | 22.8 | 22.3 | 24.6 | 24.3 | 21.7 |
| Rutland | 101.1 | 97.2 | 84.9 | 74.6 | 77.8 | 80.3 | 78.7 | 71.2 | 77.1 | 79.8 |
| Southwestern | 58.6 | 54.7 | 46.0 | 45.5 | 45.5 | 48.2 | 50.7 | 48.5 | 47.9 | 44.7 |
| Springfield | 25.0 | 23.4 | 20.4 | 18.6 | 20.6 | 22.0 | 22.1 | 19.7 | 19.5 | 19.9 |
| Total | 640.6 | 584.2 | 519.6 | 502.2 | 530.9 | 547.6 | 546.0 | 530.0 | 514.6 | 491.7 |

**Mental Health ADC as Percent of All Discharges ADC, All Ages**

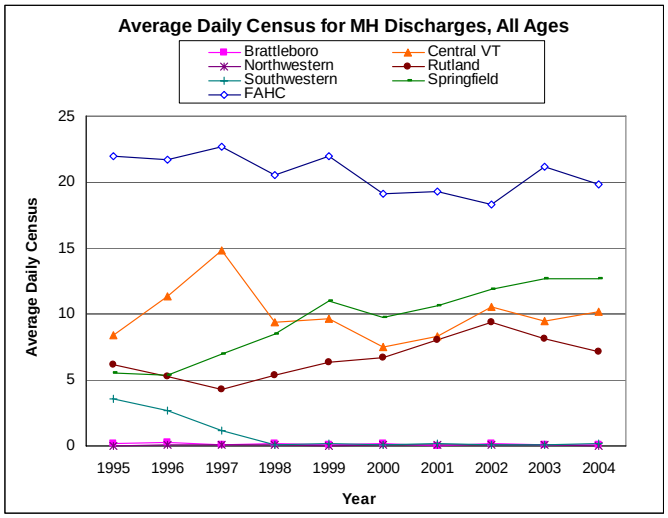
| Hospital | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|---|---|---|---|---|
| Brattleboro | 0.5% | 0.8% | 0.3% | 0.6% | 0.4% | 0.8% | 0.0% | 0.6% | 0.6% | 0.4% |
| Central VT | 14.7% | 20.3% | 28.4% | 23.3% | 22.0% | 17.9% | 19.3% | 23.6% | 24.2% | 26.6% |
| FAHC | 6.1% | 6.7% | 7.5% | 6.7% | 6.7% | 5.7% | 5.8% | 5.6% | 6.8% | 6.7% |
| Northwestern | 0.1% | 0.3% | 0.4% | 0.3% | 0.2% | 0.5% | 0.4% | 0.4% | 0.3% | 0.2% |
| Rutland | 5.8% | 5.1% | 4.8% | 6.8% | 7.5% | 7.7% | 9.2% | 11.7% | 9.5% | 8.2% |
| Southwestern | 5.8% | 4.7% | 2.5% | 0.2% | 0.5% | 0.3% | 0.4% | 0.3% | 0.2% | 0.5% |
| Springfield | 18.2% | 18.8% | 25.6% | 31.4% | 34.8% | 30.6% | 32.5% | 37.6% | 39.5% | 38.9% |
| Total | 6.7% | 7.4% | 8.8% | 8.1% | 8.5% | 7.3% | 7.9% | 8.7% | 9.2% | 9.3% |

As the table suggests and the graphs below indicate, the overall trend line for hospitals' acute care ADC is flat or declining while Mental Health ADC trends have gone up for Springfield

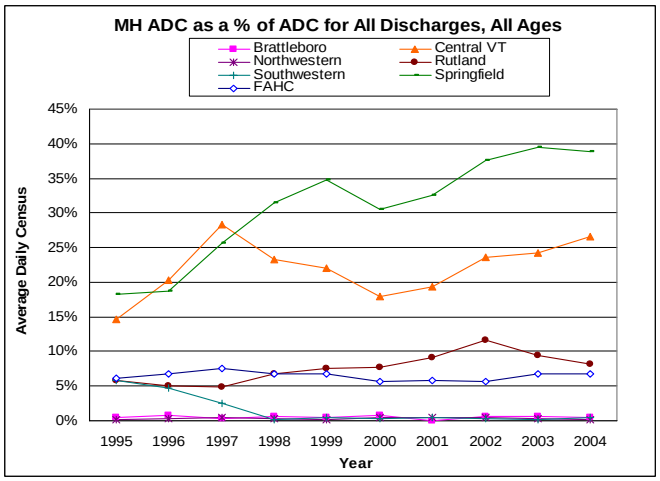
Hospital, Rutland Regional Medical Center and Central Vermont Medical Center. Psychiatric discharges have actually declined at Fletcher Allen Health Care and remained flat for the other hospitals. MH ADC as a percent of ADC has, with the exception of Southwestern Vermont Health Care, remained flat or rose over the period 1995-2004.




Graph 4 Vermont Department of Health July 2006




Graph 5 Vermont Department of Health July 2006




Graph 6. Vermont Department of Health July 2006

## f. Analysis of Specific IMD Risk

As Brattleboro Memorial Hospital, Northwestern Medical Center and Southwestern Vermont Health Care do not currently operate psychiatric inpatient services, even if they were interested in doing so, it would be difficult for them to develop the program and staff infrastructure required to operate psychiatric inpatient care at the specialized program level.

The analysis of IMD risk suggests that, excluding hospitals with no existing staffed psychiatric beds, only FAHC and RRMC could add 10 to 20 additional psychiatric beds without risk of triggering withdrawal of Medicaid funds. (The Retreat Health Care is already classified as an IMD.) Analysis of trend data is required to adequately assess the potential risk of triggering the IMD rule.

### i. Assumptions

In order to better understand what the true capacity for adding psychiatric beds to Vermont's community hospitals might be, a utilization analysis was performed taking into account the 10 year data presented above. The trend analysis presented here is based on the following assumptions:

1. The historic utilization at VSH and the Milliman projections of needed bed capacity would support an assumption of 95% utilization of new psychiatric beds.

2. Predicted rates of bed utilization can be used as a proxy measure to calculate mental health average daily census. In this analysis it is assumed that new psychiatric beds in community hospitals to replace VSH inpatient beds will have a 95% utilization rate and that this number can be used to calculate long term predictions of average daily census.

3. A variety of interacting variables will impact long term inpatient utilization trends. Among these are: the drive for cost containment, quality improvement strategies, the substitution of outpatient for inpatient procedures, efficiencies that may result from electronic information systems, improvements in health status of the population as a consequence of prevention and improved management of chronic disease, all of which may diminish inpatient utilization. Improved access for people with mental illnesses and the aging of the general population are likely to increase utilization. What the ultimate trend of the interaction of these complex variables will be over a 10 year time span is unknown. However, given the long term historical trend of the past 10 years, it is reasonable to assume that the current stable trend will continue. Accordingly, efforts to calculate IMD risk will assume that total average daily acute care census will remain stable for the period 2004-2014.

4. By contrast, estimates of untreated mental health conditions in the population and the probable decrease in stigma achieved through integrating mental health with other health services would suggest that Mental Health Average Daily Census (MH ADC) will continue to rise. However, due to care management and the availability of sub-acute care beds and other community services, it will do so at a slower rate. Based on the actuarial analysis, it is assumed that mental health utilization will increase approximately 1% per year[51]

[51] Milliman, p 43

5. Further because of the limitations on the number of psychiatric beds, Critical Access Hospitals (which are limited to 10 psychiatric beds) are not considered candidates for replacement of VSH bed capacity. This then rules out consideration of the Windham Center (Springfield Hospital)'s psychiatric unit as well as Copley Hospital, Gifford Medical Center, Grace Cottage Hospital, Mt Ascutney Hospital and Health Center, North Country Health System, Northeastern Vermont Regional Medical Center and Porter Medical Center. Additionally, due to the lack of inpatient psychiatric units, Brattleboro Memorial Hospital, Northwestern Medical Center and Southwestern Vermont Health Care will not be considered as likely candidates to replace VSH level specialized care beds. However, in order to consider the largest possible number of options, these hospitals will be included in the analysis of IMD risk (See Table 7) .

Given the assumptions above, and the small size of most of Vermont's hospitals, actual options for identifying replacement sites for psychiatric beds for VSH are limited. The Tables below illustrates the problem.

**ii. Predicted Risk of IMD Trigger for Six Hospitals**

The table illustrates the potential long range risk of adding psychiatric beds to general hospitals.

The number in the third column below, "Total Mental Health ADC 2014" is composed of existing (2004) MHADC adjusted for the 1% annual assumed increase in mental health average daily census, plus assumed additional mental health beds calculated at 95% utilization (10 beds = 9.5 MHADC; 16 beds = 15.2 MHADC; 20 beds = 19 MHADC).

The difference between the third and the fifth columns in the tables below is the margin between the number of psychiatric beds a hospital could have in 2014 and the IMD "Trigger Point," e.g., psychiatric census exceeds 50% of acute care census.

**Table 7**
**Mental Health Inpatient Staffed Bed Capacity Analysis**
**Risk of IMD Exclusion 2004-2014 Calculated From 2004 Inpatient Average Daily Acute Care Census***
**HOSPITALS THAT CURRENTLY HAVE DEDICATED INPATIENT PSYCHIATRIC UNITS**

| Hospital | MHADC 2004 | All Other Acute Care ADC 2004 | Total MHADC 2014 | Total ADC 2014 | 50% "Trigger Point" | Bed Margin Between MHADC and "Trigger Point" |
|---|---|---|---|---|---|---|
| **ASSUME 10 ADDITIONAL PSYCHIATRIC BEDS** | | | | | | |
| CVH | 10.2 | 28 | 20.94 | 48.94 | 24.47 | 3.53 |
| FAHC | 19.8 | 275..1 | 31.71 | 306..81 | 153.4 | 121..69 |
| RRMC | 7.1 | 79.8 | 7.96 | 97.26 | 48.63 | 47.67 |
| **ASSUME 16 ADDITIONAL PSYCHIATRIC BEDS** | | | | | | |
| CVH | 10.2 | 28 | 26.6 | 54.64 | 27.32 | 0.72 |
| FAHC | 19.8 | 275.1 | 37.42 | 312..51 | 156..25 | 118.83 |
| RRMC | 7.1 | 79.8 | 23.16 | 102..96 | 51.48 | 28.32 |
| **ASSUME 20 ADDITIONAL PSYCHIATRIC BEDS** | | | | | | |
| CVH | 10.2 | 28 | 30.44 | 58.44 | 29.22 | -1.22 |
| FAHC | 19.8 | 275.1 | 41.21 | 316..31 | 158.15 | 116.94 |
| RRMC | 7.1 | 79.8 | 26.96 | 106.76 | 53.38 | 26.42 |

*Vermont Department of Health, July 26, 2006. Methodology assumes 95% utilization rate for New MH beds: 10 beds = 9.5 New MH ADC; 16 beds = 15.2 New MH ADC; 20 = 19 New MH ADC. Total Acute Care ADC = Existing MH ADC + New MH ADC + All Other Acute Care ADC. Existing MH ADC is assumed to increase 1% annually (Milliman, p 43). The numbers in the table were calculated by assuming 2004 MHADC increases 12.16% by 2014. The difference between the third and the fifth columns in the table is the margin between the number of psychiatric beds a hospital could have in 2014 and the IMD "Trigger Point"

As the table indicates only two hospitals, FAHC and RRMC, could easily expand their psychiatric bed capability by adding 10 or more new beds without triggering the IMD exclusion penalty. While Central Vermont Medical Center would appear to be able to add 10 beds, this would bring their Total Average Daily Census by 2014 to 48.94 (of which Mental Health Average Daily Census would equal 20.94) and create a trigger point of 24.47. The bed margin before triggering the IMD exclusion would be 3.53; this would require very careful management of daily census in order to avoid the IMD classification.

Without additional study, it is difficult to know just what the margin of beds on the ADC would need to be for a particular hospital. Prudent policy would suggest that an average mental health ADC of less than 5 to 10 beds below the trigger point would be difficult to manage. While possible to implement, the practical effect of such tight margins would be to require very close and careful management of the average daily census to avoid the trigger. In effect, the psychiatric service would drive utilization management decisions.

If all other variables were equal (cost of developing and staffing a dedicated psychiatric unit and interest in doing so being the most important factors) Brattleboro Memorial Hospital, Northwestern Medical Center and Southwestern Vermont Health Care could each possibly add ten beds. Of the three hospitals, however, only Southwestern Vermont Health Care could add 16 or more beds without triggering the IMD exclusion. The development of new psychiatric beds in southeastern or southwestern Vermont would not enhance geographic distribution of care. Finally, to date, none of these hospitals have expressed interest in developing psychiatric inpatient services.

## Table 8
## Mental Health Inpatient Staffed Bed Capacity Analysis
## Risk of IMD Exclusion 2004-2014 Calculated From 2004 Inpatient Average Daily Acute Care Census*

**HOSPITALS THAT CURRENTLY HAVE NO DEDICATED INPATIENT PSYCHIATRIC UNITS**

| Hospital | MHADC 2004 | All Other Acute Care ADC 2004 | Total MHADC 2014 | Total ADC 2014 | 50% "Trigger Point" | Bed Margin Between MHADC and "Trigger Point" |
|---|---|---|---|---|---|---|
| **ASSUME 10 ADDITIONAL PSYCHIATRIC BEDS** | | | | | | |
| Brattleboro Memorial | 0.1 | 22.4 | 9.61 | 32.01 | 16 | 6.39 |
| Northwestern | 0 | 21.7 | 9.5 | 31.2 | 15.6 | 6.1 |
| Southwestern | 0.2 | 44.7 | 9.82 | 54.52 | 27.26 | 17.44 |
| **ASSUME 16 ADDITIONAL PSYCHIATRIC BEDS** | | | | | | |
| Brattleboro Memorial | 0.1 | 22.4 | 15.3 | 37.81 | 18.9 | 3.6 |
| Northwestern | 0 | 21.7 | 15.2 | 36.9 | 18.45 | 3.25 |
| Southwestern | 0.2 | 44.7 | 15.52 | 60.22 | 30.11 | 14.59 |
| **ASSUME 20 ADDITIONAL PSYCHIATRIC BEDS** | | | | | | |
| Brattleboro Memorial | 0.1 | 22.4 | 19.1 | 41.5 | 20.8 | 1.7 |
| Northwestern | 0.1 | 21.7 | 19 | 40.7 | 20.35 | 1.35 |
| Southwestern | 0.2 | 44.7 | 19.32 | 64.02 | 32.01 | 12.69 |

*Vermont Department of Health, July 26, 2006. Methodology assumes 95% utilization rate for New MH beds: 10 beds = 9.5 New MH ADC; 16 beds = 15.2 New MH ADC; 20 = 19 New MH ADC. Total Acute Care ADC = Existing MH ADC + New MH ADC + All Other Acute Care ADC. Existing MH ADC is assumed to increase 1% annually (Milliman, p 43). The numbers in the table were calculated by assuming 2004 MHADC increases 12.16% by 2014. The difference between the third and the fifth columns in the table is the margin between the number of psychiatric beds a hospital could have in 2014 and the IMD "Trigger Point."

### g. Create Three or More 16 Bed Hospitals

The final option to avoid classification as an IMD would be to create three or more 16-bed hospitals. These would each need to be separately licensed, and have individual boards of directors and management. In order to be a program certified to participate in federal reimbursement, each program would need to meet all the requirements of a hospital. Table 9 shows that while this option offers the advantages of securing federal reimbursement there are few economies of scale for operating costs and programmatic infrastructure. Further, the initial and very preliminary costs estimates of this application address the preferred option. It would require CON permission to develop in depth plans and cost estimates for other options.

## 4. Summary of IMD Options Analyses

As earlier stated, two key policy drivers led to the identification of the preferred scenarios outlined in this application. First, is to improve clinical care through the integration of psychiatric care with general inpatient care and by creating two new levels of inpatient services: specialized and intensive. The second policy driver is financial sustainability such that the new inpatient programs can participate in the federal Medicaid reimbursement. As such, these programs cannot be classifiable as an IMD.

### a. The Possible Options

The options that result from the IMD analysis are:

- Operate the primary and secondary programs under the license of a general hospital. Only Fletcher Allen Health Care and Rutland Regional Medical Center are large enough to host the 50-beds we anticipate requiring.
- Create three or more 16-bed hospitals.

The options that best meet the twin goals of integration with general health care and avoidance of the IMD trigger are to develop the preponderance of beds with FAHC and RRMC.

The other option is for Vermont to build a single, state-run program classified as an IMD and to simply forgo the federal funds. This option is significantly less clinically sound and, because of the lack of federal participation, is more expensive in terms of ongoing operations.

## 5. Inpatient Partner Interest

As discussed previously, throughout the course of the planning project the Division of Mental Health solicited the interest of all of Vermont's hospitals to provide new inpatient programs to replace VSH-level care. To date, the only hospitals that have committed to detailed exploration of the feasibility of providing such care are: Fletcher Allen Health Care, Rutland Regional Medical Center, and the Retreat Health Care.

## 6. Programmatic Infrastructure and Staffing Requirements

The operation of psychiatric inpatient programs at the level of specialized and intensive care will require significant infrastructure in psychiatric treatment programming and specialty staffing. Such programming requires the following attributes and characteristics.

- Ability to accept all clinically- eligible admissions (requires ongoing staffing and participation in a triage system)

- Ability to manage the most dangerous behavior safely
- Programming that meets active treatment standards for longer term admissions (in excess of 30 days)
- Diagnostic and treatment capacity for complex co-morbid conditions (both physical and mental)
- Capability to provide emergency involuntary interventions
- Ability to engage patients who may refuse to participate in treatment
- Interface with the legal system for hospitalization and in rare instances, non-emergency-involuntary medications.
- Capacity to create complex discharge plans via collaboration with community partners state-wide

The staffing requirements include psychiatrists, psychiatric nurses, and specially trained psychiatric staff (called psychiatric technicians at VSH).

The leaders of Vermont's inpatient psychiatric programs feel it will be extremely difficult for a hospital without experience in these areas to create such a program; and therefore recommended that the Division of Mental Health seek partners from among those hospitals with psychiatric inpatient expertise.

**7. Summary of the Planning Considerations**

Preliminary analyses of these proposals require consideration of costs (both construction and operating), strategies to achieve and retain adequate and sustainable financing of the system, and how best to manage the system effectively. The latter issue becomes especially significant in a zero-reject policy [52]that will require careful coordination of resources across a state-wide system. Another consideration is how to provide quality oversight, as well as how to retain, recruit and train a skilled workforce. Still another, and highly important criterion, is whether the resulting system brings together in a therapeutic environment the "critical mass" of staff, patients, and financing sufficient to support the quality improvement and care management systems necessary to provide the contemporary standard of care. Finally, even though some hospitals may have the physical beds to house expanded psychiatric capacity, they may have no staff or little interest in doing so. Willing and capable partners are a primary criterion.

The creation and the siting of new inpatient psychiatric beds require that all these different criteria be considered and balanced. The chart below delineates the various dimensions involved in selecting the design and location of the VSH replacement. Each model option is rated either "High," "Medium," or "Low," according to the likelihood that the criterion will be met. This schematic is presented without any attempt to weight or assign values to the various dimensions. The intent is simply to illustrate the complexity of the trade-offs involved in settling on a particular design.

[52] A "zero reject" policy means that all patients requiring inpatient care are admitted to the appropriate level of care in the system. No one is turned away who requires treatment and protection.

**Table 9 Criterion by Program Design Options**

| Criteria | Single Program State Run | Single Program Privately Operated (FAHC) | Primary Program W/ 1 or 2 Local Hospital Enhancements (FAHC & RRMC & Retreat Health Care | Multiple Programs With 3 or More 16- Bed Independently Operated Hospitals |
|---|---|---|---|---|
| Avoids Classification of IMD (Federal Reimbursement) | LOW | HIGH | HIGH | MEDIUM |
| Management Accountability & Feasibility | HIGH | HIGH | HIGH – MEDIUM | LOW |
| Retain Current Workforce | HIGH | HIGH-MEDIUM | MEDIUM | LOW |
| Attract Future Workforce | MEDIUM | HIGH | HIGH | LOW |
| Lowest Capitol Construction Costs | LOW | HIGH | HIGH | MEDIUM |
| Lowest Ongoing Operating Costs | HIGH | MEDIUM | MEDIUM | HIGH |
| Improved Geographic Access | LOW | LOW | MEDIUM | HIGH |
| Consistency with Stakeholder Recommendations | LOW | MEDIUM | HIGH | LOW |
| Willing and Capable Partners | NA | HIGH | HIGH | LOW |
| Integration of Mental Health & Health Services | LOW | HIGH | HIGH | MEDIUM |
| System Design Creates “Critical Mass” | LOW | HIGH | MEDIUM | LOW |

Table 9 Criterion by Program Option

As the Table indicates, preliminary consideration of the dimensions that must be balanced suggests that Fletcher Allen Health Care and Rutland Regional Memorial Hospital present the best option for partnering to develop new psychiatric inpatient programs integrated with other medical services.

## VII Project Financing

Reliable estimated capital costs associated with this project will be determined during the Phase II planning process after the Conceptual CON is granted. Partner input has not yet occurred with respect to developing the cost estimates and potential operational savings associated with co-location. There is no representation in this application that any partner (FAHC, RRMC or Retreat Health Care) has agreed to any of the project cost estimates herein, nor has any partner made any promise to fund any part of the project.

At the specific suggestion of BISHCA staff the operating cost estimates presented in this application are based solely upon current actual operating costs at VSH and should not be relied upon as indicative of costs associated with operating the new inpatient programs envisioned in the Futures Plan. In fact, it is likely that the VSH actual costs for SFY 2006 will be less than the operating costs for the new inpatient programs in the future, regardless of model or configuration.

## A. Operating Costs

Operating costs are based on VSH actuals. The following Tables are appended to this application.

I. Project cost table (BISHCA Table 1)
II. Anticipated sources of funds (BISHCA Table 2)
III. Latest actual income statement (BISHCA Table 3A)
IV. Latest actual balance sheet (BISHCA Table 4A)
V. Statement of cash flow ( without project) (BISHCA Table 5A)
VI. Revenue Source projections (without project) (BISHCA Table 6A)
VII. Utilization projections: totals (BISHCA Table 7)
VIII. Utilization projections: project specific (BISHCA Table 8)
IX Staffing Projections (BISHCA Table 9)

## B. Construction Costs

### 1. Preliminary Cost Estimates

There is no representation in this application that any partner (FAHC, RRMC, or Retreat Health Care) has agreed to any of the project costs below. An Architectural Firm, Architecture Plus (A+) was engaged by the Vermont Department of Buildings and General Services (BGS) to work with the Futures Project stakeholders to develop a preliminary "Program of Space." In addition, the contract issued by BGS also included the following elements in the scope of work:

- Conduct a preliminary assessment of the feasibility of construction and renovation on various sites;
- Develop preliminary capital construction cost estimates.

Architecture Plus (A+) has completed this preliminary analysis and their findings are outlined below.

These figures provide theoretical ranges for capital construction costs based on multiple scenarios using different methodologies. The range was developed by Frank Pitts of A+ and an independent cost estimator under contract with A+. There was only very limited input from Fletcher Allen Health Care and Rutland Regional Medical Center. The initial estimate to create 32 bed capacity developed by A+ was enlarged by Building and General Services project architect Mike Kuhn to provide an estimate of costs associated with 40 beds

For the primary inpatient program at Fletcher Allen Health Care, three different program approaches are under consideration:

- **40-bed stand alone facility.** This estimate would build the primary program on or off the campus of FAHC. Stand alone facilities require larger square footage than integrated

units because all the functions of a hospital need to be created for that facility (kitchen, admissions, administration and so forth.).

Theoretical cost range: $43 -$58.5 million

- **40-bed integrated facility.** This offers the opportunity to create the primary program in a manner that is physically integrated with inpatient care at FAHC.
  This design allows for less square footage because the host facility provides some of the functions. However, on the FAHC campus a program attached to the inpatient core will likely require more site development costs including replacement parking.

  Theoretical cost range: $46.5 - $60 million

- **68-bed integrated facility.** This design incorporates the existing 28-bed program that FAHC currently operates with the 40 new beds. It also reflects the higher site development costs of the integrated options.

  Theoretical cost range: $69 - $86 million

The integrated models do not reflect the costs of any infrastructure improvements to the host hospital that may be required in order to service the new beds.

The above estimates are based on facility sizes developed in the preliminary Program of Space Needs. With more detailed site and operational plans the range of theoretical costs for each scenario should be narrowed.

Design for the secondary program at Rutland Regional Hospital has considered various floor plan options, all of which involve expanding into space adjacent to the existing psychiatric inpatient unit and re-working the floor plan of the current unit. This may allow for better use of the existing bed capacity and for more flexibility for the provision of various levels of care.

- Renovation could add 6 new beds to the licensed 19 resulting in a total capacity of 25. The preliminary layout provides for a 13-bed locked unit, a 5-bed open unit, and a 7-bed locked unit with more intensive security and support. RRMC's current occupancy is limited to an average daily census of 10-12. This renovation will allow for sufficient program space to utilize all 25 beds, thus adding 10 – 12 more acute beds to the system.

  Theoretical cost range: $7 - $13.4 million.

## C. Conceptual CON Planning Costs

Detailed project planning costs will be developed upon granting of the conceptual CON. These costs will include but may not be limited to architectural design, financial services, construction design, and legal review. Some of these functions will be absorbed by the current state budget (such as legal review). Others may be the result of a competitive bid process. Partner participation will also be necessary for projecting planning costs and will occur in the Phase II part of this project.

Next steps in planning include:

1) Identifying consultant needs and requesting proposals where indicated for the following areas:
   - Architectural design service
   - Collaboration agreements
   - Engineering service
   - Financial services
   - Legal service

2) Develop collaboration agreements with project partners.
3) Continue to solicit community input throughout the Planning Process.
4) Identify legislative process for securing necessary appropriation for project planning.
5) Complete feasibility analyses for preferred options discussed in this conceptual CON.
6) Solidify the preferred option
7) Develop Project plan and timeline for Phase II CON Application.

# VIII HRAP CON Standards Consistency

## A. Project Need (CON Standard 1)

The HRAP sets forth the need to replace the VSH beds and calls for additional analysis on the total number of psychiatric beds needed for the services system:

> "The decertification of the Vermont State Hospital and the proposal for closure of that facility means that beds to replace the VSH beds will need to be developed. While the *Vermont State Hospital Futures Plan* suggests that there is not a need to add additional beds beyond those at VSH, capacity at other locations will need to be added to replace the existing beds. There should be further analysis of the geographic distribution of capacity and need to determine the best location and number of beds."[53]

Epidemiological Catchment Area estimates indicate on-going need for inpatient services for individuals who have severe and persistent mental illness. Table 9 (HRAP Table 17) below from the Health Resource Allocation Plan (August 2005) provides data on population need.

[53] HRAP, Section 3, Chapter 1, *Hospital Based Mental Health and Substance Abuse Services*, p.46

**Table 10**

Adults with Serious Mental Illness, and Hospitalization - 2002

| County | Estimated Number of Adults Experiencing Serious Mental Illness[1] | Number of Episodes of Hospitalization for Adults with Mental Health Diagnosis[2] | Number of People Hospitalized with Mental Health Diagnosis (95% Confidence Interval)[2] | Estimated Hospitalization Rate for Adults with Serious Mental Illness[3] |
|---|---|---|---|---|
| Chittenden | 7,835 | 744 | 543 (+/- 4.5) | 7% |
| Rutland | 2,591 | 676 | 463 (+/- 4.0) | 18% |
| Washington | 2,504 | 494 | 323 (+/- 3.0) | 13% |
| Windsor | 2,367 | 517 | 358 (+/- 3.3) | 15% |
| Franklin/Grand Isle | 2,138 | 241 | 178 (+/- 1.8) | 8% |
| Windham | 1,880 | 509 | 357 (+/- 3.2) | 19% |
| Addison | 1,624 | 182 | 128 (+/- 1.4) | 8% |
| Bennington | 1,483 | 295 | 184 (+/- 1.9) | 12% |
| Caledonia | 1,169 | 143 | 101 (+/- 1.2) | 9% |
| Orange | 1,129 | 233 | 150 (+/- 1.6) | 13% |
| Lamoille | 1,067 | 117 | 89 (+/- 1.2) | 8% |
| Orleans | 1,001 | 120 | 94 (+/- 1.2) | 9% |
| Essex | 223 | 23 | 20 (+/- 0.5) | 9% |
| Unknown | | 28 | 26 (+/- 0.6) | |

Source: HRAP, Chapter 1 Hospital-Based Mental Health and Substance Abuse Services, Table 17

As the table indicates, the proposed psychiatric replacement beds at Retreat Healthcare, Rutland Regional Medical Center and FAHC are located in or adjacent to the counties with the largest estimated number of adults experiencing serious mental illness, the highest number of episodes of hospitalizations and highest number of people hospitalized with mental health diagnoses.

In June 2006 Milliman Actuarial Consultants issued their *Actuarial Study of the Needed Bed Capacity for Adult Mental Health Inpatient Services*. The conclusion of the study was that needed adult mental health inpatient bed capacity (number of beds needed system wide) depends on the extent of implementation of the Vermont Futures Plan. In assessing necessary bed capacity, Milliman examined three potential scenarios: (1) Status quo; (2) Partial implementation; (3) Full implementation.

**Scenario 1: Status Quo** VSH or its successor facility would continue to operate as it currently does. The proposed additional community resources would not be created. The only changes to the need for adult mental health inpatient services would be driven by demographic shifts and normal utilization trends.

Under this Scenario the needed bed capacity at VSH would be 65 beds in 2016.

**Scenario 2: Partial Implementation** assumes the construction of new inpatient facilities, but only partial implementation of community alternative services (one-half of the planned additional community resources are assumed implemented.).

In this half-way scenario, projected VSH type bed capacity would be 53 beds in 2016.

**Scenario 3: Full Implementation** assumes full implementation of all aspects of the Futures Plan. All the service components are fully funded, fully staffed with qualified providers and completed according to schedule.

Under this scenario the needed bed capacity would be 41 beds in 2016.

The level of care required varies by scenario. See Table 10 below (Milliman, Futures Study, June 2, 2006, p. 6):

**Table 11**

| State of Vermont, Department of Health<br>Projection of 2016 Adult Mental Health Inpatient Needed Bed Capacity by Level of Care<br>Range of Scenarios | | | |
|---|---|---|---|
| Level of Care | Scenario 1<br>Status Quo | Scenario 2<br>Partial Implementation | Scenario 3<br>Full Implementation |
| ICU | 7.1 | 7.1 | 7.1 |
| SIP Unit | 57.2 | 45.3 | 33.4 |
| General | 120.0 | 117.8 | 115.7 |

The total number of beds required in 2016 by the system under the full implementation scenario is thus 156.2.

In developing this projection of needed bed capacity, Milliman assumed that induced utilization (the effect of new consumers wishing to use newly created community resources) would use 10% to 20% of the capacity of the newly created community resources, decreasing the number of the current VSH patients who could be shifted to community care. The study also poses a target bed number to reflect capacity that would be adequate 90% of the time.

The proposed inpatient bed capacity of this Futures Project CON application is consistent with the Milliman study. As currently conceived, the 54 bed capacity would be replaced with new and upgraded service capacity by adding 40 beds at FAHC, possibly 6 beds at Rutland Regional Medical Center and possibly 4 beds at Retreat Healthcare. See the table "*Impact of Full Implementation of Futures Project on Current Supply and Distribution of Type of Psychiatric Treatment Beds*" below.

Please note that the psychiatric bed capacities of the VA hospital and Dartmouth Hitchcock Medical Center are, for all practical purposes, not an available resource to replace VSH bed capacity. DMHC patients are voluntary. Moreover, DMHC's Vermont partner hospitals, based on the IMD exclusion analysis above, and their response to the 2004 survey, do not appear to be potential partners for the Futures Project. The Veterans Hospital facility is available only to Veterans.

As this Table below indicates, a fully implemented Futures Project would reduce the bed capacity at VSH to zero and increase bed capacity in Rutland to potentially a total of 25 beds Retreat Healthcare would add 4 beds, raising their overall capacity. FAHC would increase their total bed capacity from 28 beds to 68 beds. The total state psychiatric bed capacity in 2012 would thus range from 157-167 and permit expansion-contraction as needed. This figure is consistent with the Milliman Actuarial projection of 156.2 total inpatient beds required under the conditions of full implementation of the Futures Project.

**Table 12**
**Impact of Full Implementation of Futures Project on Current Supply and Distribution of Type of Psychiatric Treatment Beds**

| Hospital | Hospital Service Area | Town or City | Number ICU Beds* 2012 | Number SIP Beds **2012 | Number General Psychiatric Beds 2002 | Total Psych Bed Capacity 2012 | 2002 Licensed Psych Bed Capacity | Change in Bed Supply when Futures fully Implemented |
|---|---|---|---|---|---|---|---|---|
| CVH | Barre | Berlin | 0 | 0 | 14 | 14 | 14 | 0 |
| FAHC | Burlington | Burlington | 12 | 20-28 | 28 | 60-68 | 28 | + 40 |
| RRMC* | Rutland | Rutland | 0 | 4-6 | 19 | 23-25 | 19 | + 6 |
| Windham Center[1] | Springfield | Bellows Falls | 0 | 0 | 10 | 10 | 10 | 0 |
| Retreat Healthcare | Brattleboro | Brattleboro | 0 | 4 | 46 | 50 | 52 | +4 |
| Vermont State Hospital | Barre | Waterbury | 0 | 0 | 0 | 0 | 54 | -54 |
| Dartmouth Hitchcock Medical Center | Other | Hanover, NH | | | | (24) | (24) | 0 |
| Veterans Administration Hospital | White River | White River Junction | | | | (10) | (12) | 0 |
| **Total* Inpatient Bed Capacity** | | | **12** | **28-38** | **117** | **157-167** | 177 | -4* |

[54]From HRAP, Chapter 1, Page 40 Current Supply and Distribution. Original Source: Vermont State Hospital Futures Plan; interviews with staff from the VA Hospital and Dartmouth-Hitchcock Medical Center. Milliman, Actuarial Study of the Needed Bed Capacity for Adult Mental Health Inpatient Services. Table altered to include Licensed Bed Capacity, change in bed supply, Futures Project Staff, July 2006. 1. The Windham Center became a Critical Access Hospital in 2005. Now has a maximum capacity of 10 psychiatric beds. 2. Milliman, Actuarial Study. Estimates assume full implementation of Futures Plan. P.50. *Although RRMC has 19 inpatient psychiatric beds, at the present time, due to program space constraints, only 10 of these beds are utilized. The renovations that are envisioned in this application will provide for needed space so that all of the 19 beds will be usable. *ICU are Intensive Care beds. ** SIP are Specialized Inpatient beds.

**2. The proposed project will facilitate implementation of the HRAP concerning resources, needs and appropriate system of delivery of services.**

The Criterion Analysis of Design Options above addresses the issues for over-all system design.

The Futures Project also addresses the recommendations in the *Health Resource Allocation Plan to*:

- **Implement the Futures Report recommendations as the foundation for determining future mental health and substance abuse inpatient planning (HRAP Recommendations, Inpatient, Emergency & Hospital-Based Services, Inpatient Services, Recommendation 5, p xi.)**

This overall HRAP recommendation is addressed by both the scope and the specificity of the proposal. The number of beds proposed for the inpatient psychiatric facilities that are the subject of this Conceptual CON Application rest on the assumption that the Futures plan will be fully implemented as detailed in previous sections. Six residential beds will be relocated from VSH to a secure residential program. Eighteen (18) sub-acute care beds will be removed from VSH to one or more community recovery residences for individuals who need intensive rehabilitation, but do not need to be hospitalized. Ten (10) new diversion (crisis) beds are planned to augment the nineteen (19) existing diversion beds operated by Designated Agencies around the state. A Care Management system is envisioned that will create a service network that coordinates all system components (general psychiatric inpatient beds, specialized care psychiatric inpatient beds, intensive care psychiatric beds, mental health crisis beds, access to the new adult outpatient capacity for community reintegration, inpatient, residential and outpatient substance abuse treatment services). New resources will be devoted to Peer Services Programming, Supportive Housing and Legal Services. Sustaining resources will be provided to existing community services including adult outpatient services. The Department of Health and the Department of Corrections plan to expand the Co-Occurring Disorders Project. The Department of Health will work with primary care physicians to enhance early screening, diagnosis and treatment of mental illness, focusing initially on depression. Implementation of evidence based interventions of Offender Out-Patient Services and the Mental Health Plan for Corrections are related to the community based strategies of the Futures plan.

- **Support implementation of the broad recommendations in the Vermont State Hospital Futures Plan, including**
  - **v. An adequate number of beds to provide essential core services, including**
    1. **Inpatient beds at an appropriate general hospital (preferably an academic medical center),**
    2. **Intensive care beds at another hospital,**
       Items (1) and (2) would be addressed by proposing new intensive and specialized care beds at FAHC, and specialized program beds at RRMC, and at Retreat Health Care

    3. **Sub-acute beds in one to three locations,**
       A total of 16 beds to be assigned to one or more sub-acute care programs are planned. This program(s) will offer best practices related to recovery, cognitive rehabilitation, occupational therapy leading to supported employment, treatment for substance abuse, peer support through blended peer staffing and intensive treatment for issues related to trauma.(*Vermont State Hospital Futures Plan*, pp 28-29)

    4. **A secure residential facility,** and
       A six bed secure residential program will be developed for individuals who are considered a danger to society and have been assigned to the custody of the Commissioner, but who are not in need of hospital or sub-acute level care. These beds may or may not be in a single location. (*Vermont State Hospital Futures Plan*, p 29)

    5. **Additional diversion beds in two or three locations.**
       Ten beds are planned to augment 19 existing diversion beds in programs run by Designated Agencies around the state. Under the Futures Plan, all diversion beds would be used for: triage and observation care (24 hours),

crisis stabilization care (24-48 hours), hospital alternative care (3-7 days), hospital step-down care (24-72 hours). (*Vermont State Hospital Futures Plan*, p 31)

vi. **Location of services in or near the most appropriate setting: academic medical centers, community hospitals, or other community-based facilities.**
This application proposes to assess the most desired option for development of 40 beds connected to FAHC, the state's only tertiary hospital and academic medical center. It also seeks permission to conduct detailed feasibility analyses to select two additional sites.

vii. **Construction of new facilities when existing facilities are inadequate to meet the standard of care required for the service**
Refer to Section One, Description of the Futures Project. The proposal seeks permission to construct new facilities on or off the FAHC campus and potentially, to renovate psychiatric facilities at Rutland Regional Medical Center and at Retreat Healthcare. See the previous discussion of *Criterion Analysis of Design Options* above and *Analysis of Specific IMD Risk*, above. As an isolated, stand alone unit VSH cannot meet the quality standards for best practices for mental health service delivery. New facilities are required to achieve the current standard of integrated health and mental health care.

viii. **This implementation should include a thorough clinical and operational planning process that includes the State's hospitals. (HRAP Recommendations, Mental Health / Substance Abuse Services, Recommendation 1, p xii.)**
In August 2004 all of Vermont's hospitals were invited to participate in a collaborative planning process to determine potential location for future inpatient services. Five hospitals expressed interest: FAHC, Central Vermont, Springfield Hospital, Rutland Regional Medical Center and the Retreat Health Care. Follow-up calls were made to the other hospitals to determine interest. In December 2004 a Request for Information (RFI)
resulted in responses from 4 of the 5 hospitals with inpatient psychiatric units: FAHC, Springfield, RRMC and the Retreat Health Care. Central Vermont has consistently indicated they have no plans to change or develop their existing psychiatric facility.

- **Support proven models that integrate primary and specialty care with mental health and substance abuse care for providers who are either co-located or located off-site. . . .(HRAP Recommendations, Primary Care Services, Recommendation 8, p. xiv)**
Both the Futures inpatient proposal and the supporting community based services will enhance access to integrated mental health and substance abuse care. The Division of Mental Health has recently initiated a second grant funded project to enhance integration of mental health and substance abuse services (the SAMHSA sponsored EBP Training and Evaluation grant and the CO-SIG grant). The Futures Care Management program will facilitate referrals across the system.

- **Advance proven models that integrate primary and specialty care with mental health and substance abuse care for providers who are either co-located or located**

**off-site. .. (HRAP Recommendations, Specialty Care Services, Recommendation 5, p xvi)**

See above. These two Standards from different sections of the Health Resource Allocation Plan will both be addressed through integrating mental health with primary and specialty medical care, and through the integration of mental health and substance abuse services.

- **Increase resources for designated agency adult outpatient and substance abuse programs. (Secretary Charles P. Smith's Recommendations for the Future of Services Provided at the Vermont State Hospital, 2-4-05). This will help to ensure that Vermonters are treated in the most appropriate and least restrictive setting possible. (HRAP Recommendations, Mental Health/ Substance Abuse Services, Recommendation 3, p xvii)**

  Although not reviewed under this application, the Futures Plan includes enhanced resources for designated agency adult outpatient and substance abuse programs. See *The Vermont Mental Health Futures Plan Proposal to Transform and Sustain A Comprehensive Continuum of Care for Adults with Mental Illness Presented to the Legislative Mental Health Oversight Committee, March 22, 2006 Approved by the Committee with Two Amendments Revised April 25, 2006*, (See Appendix C). The Futures Plan objective of providing integrated care for individuals with co-occurring disorders will improve access to an array of services for individuals with these conditions who are presently the clients of the designated agencies.

- **Integrate the State's private and public systems for mental health and substance abuse treatment to improve coordination of care and achieve a comprehensive continuum of care. (HRAP Recommendations, Mental Health and Substance Abuse Services, Recommendation 9, p xviii)**

  The primary inpatient services proposal for which the Division is requesting permission to further investigate in this Application is built on the assumption of a public/private partnership between the State of Vermont and three of Vermont's private general hospitals. The proposed care management system will link inpatient and outpatient mental health services with inpatient and outpatient substance abuse services. The care management function will provide service coordination for individuals who cross multiple departmental, institutional and/or mental health program services. Development of common clinical protocols among all partners (designated agencies, diversion providers, designated hospitals, Corrections, etc.) and interoperable information systems will facilitate both care management and utilization management. See *The Vermont Mental Health Futures Plan March 22, 2006*.

- **Ensure that people experiencing mental health and substance abuse disorders have access to a full range of recovery and support services. (HRAP Recommendations, Mental Health / Substance Abuse Services, Recommendation 2, p xix)**

  As described above the inpatient services proposed under this application are but one part of a comprehensive reform of the entire system designed to provide an enhanced array of services across the continuum of care. See *The Vermont Mental Health Futures Plan March 22, 2006*.

- **Explore models of collaboration among other health professionals in order to promote physical and mental health integration. (HRAP Recommendations, Mid-Level Practitioners, Recommendation 13, p xxi)**

The proposal to site 40 inpatient psychiatric beds at FAHC, an academic teaching hospital, is expected to foster enhanced exploration and testing of new ways for other health professionals to serve individuals with severe and persistent mental illness and co-occurring disorders.

- **Develop educational opportunities to assist non-mental health specialists in addressing mental health issues more extensively within the scope of their practice, in order to utilize psychiatric nurse practitioners more effectively. (HRAP Recommendations, Mid Level Practitioners, Recommendation 14, p xxii)**

  This standard is closely related to Recommendation 13 above. The siting of the proposed primary inpatient program at FAHC is expected to greatly enhance education and training opportunities for an array of health and mental health professionals. Physicians and nurses particularly will, due to the availability of a larger patient population, have greater opportunity to develop relevant skills and knowledge to better serve patients with severe and persistent mental illnesses.

**3. The project will meet the needs of the medically underserved groups and the goals of universal access to health services (CON Standard 4)**

The proposed application will improve medical services for involuntary psychiatric patients who often have limited access to health care services in the community. In addition, subsequent to the passage of Act 53 in 2003, every four years, each hospital in the State of Vermont is required to conduct an assessment of the needs of the community it serves (HRAP, Community Needs Assessment Summary, p xli). In the Summary Report included in the HRAP, additional mental health and substance abuse services were a high priority item across all 16 hospital service areas (p.xlii).

www.bishca.state.vt.us/HcaDiv/HRAP_Act53/hosp_reports_indiv_index.htm

In the **Brattleboro Memorial Hospital** service area increased access to adult mental health services including psychiatric care, case management and coordination of care was the 4th of 13 highest rated item among needed health resources. In the **Retreat Health Care** community needs assessment, increased access to adult mental health services including psychiatric care, case management and coordination of care was ranked third of six high priority areas. The Community Health Assessment Advisory Committee identified an overarching theme as the need for

> Greater coordination …among the many "silos" of mental health and substance abuse providers and programs in the community, in order to create an integrated continuum of mental health and substance abuse care" (p. 2).

The addition of 4 specialized care beds at the Retreat Health Care and the connection of Retreat services to the statewide Case Management System should improve coordination of care both locally and with other mental health resources around the state.

The **FAHC** service area needs assessment reported that "Mental illness is also of concern in our community, with 10 percent of adults being at risk for depression and an age-adjusted death rate of 9.8 / 100,000 population for intentional self-harm (suicide)" (p 16) .

"Psychoses account for 66 percent of our inpatient mental illness episodes, and depressive neuroses account for 11 percent. (p.16) …. Mental illness and substance abuse account for 5 percent of all our Emergency Department visits "(p. 17). Admissions data reflects the fact that "our hospital admits patients from all counties in Vermont, without exception" (p 17). Within its catchment area FAHC serves "one Federally Qualified Health Care Center (The Community Health Center of Burlington), one integrated free clinic (The Health Access Program at Fletcher Allen Health Care), and one rural health center (Keeler Bay Family Practice), all of which have a specific mission to serve the disadvantaged" (p18).

An identified FAHC gap is the shortage of adult and pediatric psychiatrists (p.20).

By siting a major inpatient psychiatric facility with FAHC (and strengthening community services), the pressure of mentally ill individuals seeking service through the emergency room should be relieved. Additionally, it is expected that access to care among the low-income community will be increased.

In its community needs assessment **Rutland** identified mental illness among the top 25 diagnostic related groups (p7). Statistical data provided by the Department of Health indicates that Rutland area residents are at greater risk for depression than Vermonters as a whole (12.3% vs. 11.3%) and has an age adjusted suicide rate of 15.2% (vs. 12.5% for Vermont statewide). An average of 10 suicide deaths a year occur in the Rutland Service Area. Three percent of all Emergency Department visits were for Mental Illness or Substance Abuse (p 12). The Rutland numbers represent 13.4% of the State's total visits for these diagnoses, disproportionately higher than the service area population. Approximately 90% (90.6%) of these Emergency Department visits were from Rutland County. The remaining visits were from Windsor, Addison, Bennington and Chittenden Counties (p 13).

This data would suggest that access to augmented and integrated mental health services targeting Rutland and surrounding counties is needed.

It should be noted that while the primary focus of this CON Application is the development of adult inpatient mental health services, all the Community Needs Assessment data from Vermont hospitals describe the need for more substance abuse services and for the integration of these services with mental health services. A key element of the Futures Plan is enhanced treatment options and coordination of mental health and substance services. Implementation of the full Futures Plan will go far toward enhancing access among this group of medically underserved people regardless of socioeconomic or insurance status. Additionally, the enhanced support for community services that is a central element of the Futures Plan will address the wide-spread gap identified in outpatient services.

### 4. The project fosters the Vermont Blueprint for Health (CON Standard 6)

Improving care and outcomes for patients with chronic disease, including those with persistent mental illness requires knowledgeable consumers practicing improved self care, a practice team providing timely planned care, improved information (data), decision support, office systems and supportive community, health care and public health infrastructure. The Vermont Blueprint for Health, which is based on the Chronic Care Model (CCM), provides an essential organizing structure for managing the care of people with long-term, complicated health problems. The goal of enhancing clinical and functional outcomes is

predicated on planned, proactive care by the provider and an activated, informed consumer who work together to set and accomplish treatment goals. Use of the CCM as a tool for improving care for individuals with more severe exacerbations of mental illness has been piloted by the Office of Vermont Health Access, community mental health agencies and primary care providers over the past several years with promising results. This project integrates mental health care into settings where other health and social services are delivered thereby increasing opportunities for patients and communities to acquire the knowledge and skill they need to achieve recovery[55]. Moreover, the Futures Care Management system is consistent with the electronic information system and the care management capabilities embodied in the Blue Print. It is expected that as the system is implemented, it may become possible to electronically link and integrate the care record of persons with mental illness who have other medical conditions. This integrated record system is expected to improve the quality of patient care. (See also discussion #6 that follows.)

**5. The project proposes to, or is likely to, expand geographic access to services (CON Standard 7).**

As HRAP data indicates (See HRAP Table 17 below**)** the counties with the highest estimated number of individuals experiencing serious mental illness are Chittenden, Rutland, Washington, Windsor, Franklin Grand Isle and Windham. Expanding the inpatient bed capacity in the Burlington, Rutland and Brattleboro areas would presumably enhance access to services.

[55] Vermont State Health Plan 2005, online: http://HealthVermont.gov/pubs/HealthPlan5.pdf

**Table 13***
**Adults with Serious Mental Illness, and Hospitalization - 2002**

| County | Estimated Number of Adults Experiencing Serious Mental Illness[1] | Number of Episodes of Hospitalization for Adults with Mental Health Diagnosis[2] | Number of People Hospitalized with Mental Health Diagnosis (95% Confidence Interval)[2] | Estimated Hospitalization Rate for Adults with Serious Mental Illness[3] |
|---|---|---|---|---|
| Chittenden | 7,835 | 744 | 543 (+/- 4.5) | 7% |
| Rutland | 2,591 | 676 | 463 (+/- 4.0) | 18% |
| Washington | 2,504 | 494 | 323 (+/- 3.0) | 13% |
| Windsor | 2,367 | 517 | 358 (+/- 3.3) | 15% |
| Franklin/Grand Isle | 2,138 | 241 | 178 (+/- 1.8) | 8% |
| Windham | 1,880 | 509 | 357 (+/- 3.2) | 19% |
| Addison | 1,624 | 182 | 128 (+/- 1.4) | 8% |
| Bennington | 1,483 | 295 | 184 (+/- 1.9) | 12% |
| Caledonia | 1,169 | 143 | 101 (+/- 1.2) | 9% |
| Orange | 1,129 | 233 | 150 (+/- 1.6) | 13% |
| Lamoille | 1,067 | 117 | 89 (+/- 1.2) | 8% |
| Orleans | 1,001 | 120 | 94 (+/- 1.2) | 9% |
| Essex | 223 | 23 | 20 (+/- 0.5) | 9% |
| Unknown | | 28 | 26 (+/- 0.6) | |

[1]Calculated by multiplying prevalence rates for adults with serious mental illness (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Estimation of 12 Month Prevalence of Serious Mental Illness (SMI)," 1997) by estimated 2002 population of adults 18 and over (Vermont Department of Health, Center for Public Health Statistics, "Vermont Intercensal Population Estimates, 2002 Vermont Population Estimates," March, 2002

[2]Information is derived from the Hospital Discharge Data Set maintained by the Vermont Health Department, and database extracts provided by the Brattleboro Retreat and Vermont State Hospital. Because these data sets do not share unique person identifiers, Probabilistic Population Estimation was used to determine caseload size (with 95% confidence intervals). Hospital discharge data were supplied by the Vermont Association of Hospitals and Health Systems - Network Services Organization and the Vermont Department of Banking, Insurance, Securities and Health Care Administration. These organizations disclaim responsibility for analyses, interpretations and conclusions, and BISHCA disclaims responsibility for errors in the data.

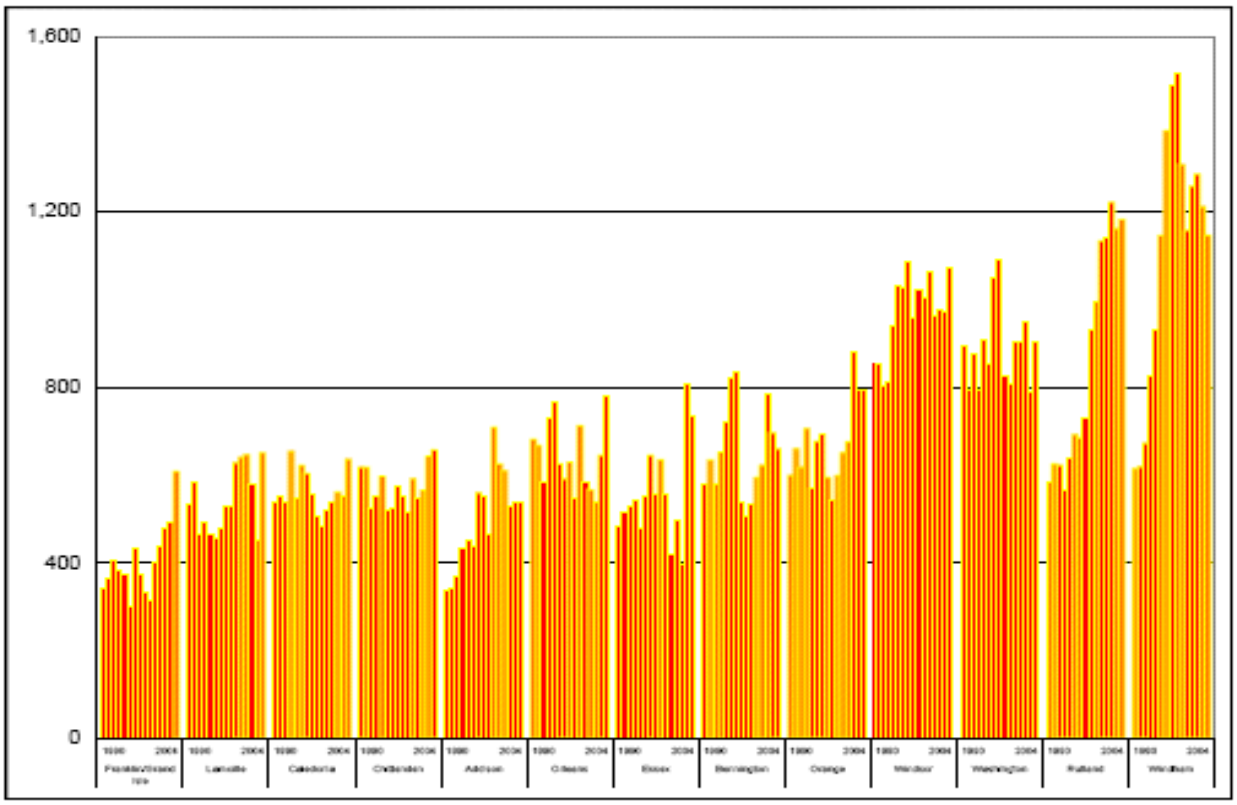
[3]Calculated by dividing "Estimated Number of Adults Experiencing Serious Mental Illness" by "Number of People Hospitalized with Mental Health Diagnosis".

However, county of residence, with the exception of Rutland County, while influencing choice of hospitals, does not appear to determine where an individual ultimately chooses to be hospitalized See below Episodes of Hospitalization for Behavioral Health Care, Vermont Residents by County of Residence and Hospital: CY2004, John Pandiani, Vermont Department of Health 2006**.**

* Note: This table appears twice for ease of reference.

**Table 14**

Episodes of Hospitalization Per 100,000 Population
for Behavioral Health Care, Vermont Residents: 1990 - 2004




Episodes per 100,000 Population by County of Residence

| | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 619 | 619 | 596 | 639 | 679 | 680 | 740 | 728 | 709 | 720 | 752 | 748 | 782 | 768 | 814 |
| Franklin/Grand Isle | 342 | 366 | 407 | 382 | 373 | 302 | 435 | 375 | 331 | 314 | 401 | 439 | 479 | 493 | 609 |
| Lamoille | 532 | 582 | 465 | 493 | 465 | 456 | 480 | 529 | 531 | 628 | 641 | 647 | 581 | 453 | 651 |
| Caledonia | 539 | 550 | 540 | 655 | 549 | 623 | 604 | 557 | 506 | 481 | 522 | 540 | 562 | 551 | 637 |
| Chittenden | 619 | 618 | 522 | 551 | 596 | 522 | 526 | 576 | 554 | 514 | 592 | 545 | 566 | 644 | 658 |
| Addison | 340 | 343 | 367 | 432 | 453 | 437 | 560 | 554 | 466 | 709 | 625 | 610 | 531 | 536 | 540 |
| Orleans | 682 | 668 | 584 | 729 | 766 | 625 | 592 | 630 | 549 | 714 | 582 | 567 | 537 | 646 | 782 |
| Essex | 484 | 516 | 531 | 543 | 479 | 554 | 645 | 557 | 636 | 559 | 418 | 495 | 397 | 807 | 736 |
| Bennington | 577 | 636 | 578 | 652 | 722 | 824 | 836 | 538 | 508 | 532 | 595 | 623 | 786 | 697 | 660 |
| Orange | 600 | 661 | 618 | 706 | 570 | 677 | 693 | 595 | 542 | 600 | 652 | 676 | 882 | 794 | 795 |
| Windsor | 855 | 805 | 813 | 938 | 1,032 | 1,026 | 1,088 | 960 | 1,025 | 1,006 | 1,062 | 964 | 979 | 974 | 1,072 |
| Washington | 894 | 794 | 876 | 795 | 908 | 854 | 1,048 | 1,090 | 827 | 809 | 903 | 904 | 950 | 792 | 902 |
| Rutland | 586 | 626 | 623 | 565 | 639 | 692 | 686 | 729 | 931 | 995 | 1,134 | 1,142 | 1,222 | 1,162 | 1,184 |
| Windham | 616 | 620 | 673 | 825 | 931 | 1,147 | 1,386 | 1,488 | 1,516 | 1,309 | 1,158 | 1,259 | 1,286 | 1,212 | 1,147 |

Information is derived from the Hospital Discharge Data Set maintained by the Vermont Health Department, and database extracts provided by the Brattleboro Retreat and Vermont State Hospital. Behavioral health care includes both mental illness and substance abuse.

In their analysis of Patient Residence and Hospital Location (June 30, 2006) John Pandiani and Joan Mongeon note that

> The number of hospitals used by residents of individual Vermont counties varied from 15 different hospitals used by residents of Windham County and 14 different hospitals used by residents of Windsor County, to 9 different hospitals used by each of four counties (Addison, Bennington, Rutland and Washington).
>
> Residents of Rutland County had the most concentrated utilization with 70% of all hospitalizations for behavioral health care being provided by Rutland Regional Medical Center, followed by Chittenden County with 65% at Fletcher Allen Health Care, and

Washington County with 52% at Central Vermont Medical Center. The least concentrated utilization was by residents of Essex County with the most used hospitals (Dartmouth Hitchcock Medical Center and the Vermont Veterans' Hospital) accounting for only 20% each.

Seven different hospitals provided inpatient behavioral health care to individuals from every Vermont County during 2004. These include the Vermont State Hospital, the Retreat Health Care, Fletcher Allen Health Care, Rutland Regional Medical Center, Springfield Hospital, the Vermont Veterans' Hospital, and the Dartmouth Hitchcock Medical Center in New Hampshire.

It appears that more than geographic access influences hospital selection. However, by dispersing intensive inpatient treatment beds to Burlington, Rutland and Brattleboro, it is likely that the most seriously mentally ill Vermonters would have the choice of increased access to appropriate care closer to their home. In the primary proposal of this application, FAHC is assumed to provide statewide coverage as a Tertiary Care Hospital, and to provide psychiatric services to residents of northern and western Vermont. The Retreat Health Care serves southern and eastern Vermont while Rutland Regional Medical Center provides psychiatric inpatient services to southern and western Vermont.

This dispersion of admission capability from its current central location in Waterbury is planned to advance geographic access for Vermonters who now have only one central location for inpatient care.

**6. The project proposes to retain access to one or more services (CON Standard 8)**

All existing services now provided at VSH will be continued in other settings. All intensive inpatient services will be provided in other hospitals. The design proposed for further exploration in this application would develop intensive care unit beds and specialized care beds with FAHC, and specialized care beds with RRMC and Retreat Healthcare. Individuals served in these new programs would be treated in environments that are specially designed to provide enhanced care. Vermonters will benefit from coordinated and integrated mental and other health services and from integrated substance abuse and mental health treatment plans. The care management system as envisioned by the Futures Plan will provide access to the right care at the right time, and will focus on improving patient outcomes appropriate to the individual's diagnosis and needs. Vermonters will benefit from the systems integration of case information and quality management the Blue Print will make available to all health providers.

Eighteen (18) sub-acute beds would be relocated from VSH to one or more community recovery residences for individuals who need intensive rehabilitation, but do not need to be hospitalized. These beds might be offered in one or two or more localities (Refer to the Futures Plan, p 28). This level of programming represents a new level of rehabilitation programming in Vermont's delivery system. The programs will be expected to offer best practices related to recovery, cognitive rehabilitation, occupational therapy leading to supported employment, treatment for substance abuse, peer support through blended peer staffing, and intensive treatment for issues related to trauma.

Six (6) residential care beds will be relocated from VSH to a secure residential setting. They would be reserved for individuals who are considered a danger to society and have been assigned to the custody of the Commissioner, but who are not in need of hospital or sub-acute level care.

These beds would serve a small group comprised of four to eight individuals at any given time. From a clinical perspective their treatment is complete and they are no longer in need of hospital care. However, they are perceived as posing a threat to public safety. The programming offered this population will include provision and monitoring of psychiatric medications, individual counseling to assist with adjustment to the residential setting and transition from the hospital, and rehabilitation services. The latter will focus on productive community living. In addition treatment for substance abuse, cognitive and/or behavioral interventions and social skills training will be available as needed. Monitoring of the patient's condition and response will be an on-going feature of this service.

All of these services will be relocated and provided according to best practices in new settings. The system wide care management system is planned to smooth access and the flow of patients to the appropriate levels of inpatient and outpatient care. The capacity of the system to serve its patient population is dependent upon the planned enhancement of existing adult outpatient services and the development of new outpatient capacities. Among these are the proposed 10 diversion beds proposed to augment the existing 19 beds currently in the system (see *The Vermont Mental Health Futures Plan,* p 31).

In developing an integrated health/ mental health system a number of infrastructure components (consistent with those of the Chronic Care Systems Model and the Blue Print) are in place. The Division of Mental Health and its network of community providers operates a client level service encounter data system, receives monthly financial reports from service providers, has business office capability and legal services, and uses these to ensure that clients' rights are protected, that the custodial role of the state is appropriately carried out, and to insure that clear and enforceable contracts with service partners are developed and maintained. Other capabilities include: clinical management system and design for standardized protocols governing the flow of patients through the system, program development and evaluation capacity and, finally, a quality management-quality improvement system to identify clear outcomes and measure progress. All these systemic components align with the Blue Print.

**7. Mental Health and Substance Abuse Services (CON Standard 16)**

**16 a The project will foster the state's focus on developing a coordinated system that encourages access to the appropriate and least restrictive level of care**

Refer to (8) above. The Futures Plan is based on the assumptions of a coordinated continuum of care provided in the least restrictive setting consistent with safety and therapeutic need.

**16 b The project reflects the desirability of retaining the designated local provider network for the treatment of individuals with long-term and severe psychiatric needs**

The Futures Plan is grounded in maintaining and enhancing the services currently provided by the Designated Agencies. In his *Recommendations for the Future of Services Provided at the Vermont State Hospital Strengthening the Continuum of Care for Vermonters with Mental Illnes*s, February 4, 2005, Secretary Charles P. Smith called for enhanced funding of the Designated Agency System.

A study of the sustainability of the Designated Agency (DA) system was completed in November of 2004 by the Pacific Health Policy Group. Among the report's chief findings are these contained in its executive summary:

> *"The Designated Agencies have, by and large, been successful in operating efficient, community-based systems for a wide range of behavioral and developmental services. The non-competitive nature of the DA system and the bottom-line regional responsibilities delegated to the Designated Agencies has fostered the development of a system of care that is highly effective in meeting the unique needs of Vermont communities."*

The DA system, administered by DMH, focuses on five programs:

- Community Rehabilitation and Treatment (CRT) – comprehensive services for adults with long term psychiatric disabilities. In SFY 04, 3,205 individuals were served.
- Adult Outpatient Services – individual and group counseling for adults with serious mental health issues. In SFY 04, 7,120 individuals were served.
- Emergency Services – evaluation and support services provided to individuals and communities experiencing a crisis. In SFY 04, 6,690 individuals were served.
- Inpatient Treatment – namely, the services at VSH and oversight responsibility for involuntary inpatient care statewide. In SFY 04, 549 individuals were served. (DMH directly operates the services at VSH and provides oversight for involuntary admissions to DAs and Retreat Healthcare and for all Medicaid-funded admissions of CRT clients and children for psychiatric inpatient care.)
- Services for Families and Children – immediate response, treatment, family support services and consultation, intensive residential, prevention and education. In SFY 04, these programs served 10,040 children.

**Regarding Community Rehabilitation and Treatment (CRT):**

Vermont's CRT programs assist adults who have been diagnosed with a mental illness and who are experiencing disability. The programs serve 3,200 individuals in any given year and help individuals and their families to develop skills and supports. The services include: prescription and monitoring of medication; community supports; helping individuals find and keep a job or a place to live, get an education, understand their mental illness, meet life goals; crisis services; social and recovery skills. From 1999 – 2005 the CRT program operated under the auspices of a Federal Section 1115 Research and Demonstration Waiver. It is the only such federal demonstration program in the country. The Global Commitment to Health Care waiver replaces this prior demonstration waiver.

Although the CRT program is relatively well developed, it faces significant challenges in staff turnover, shortage of housing for clients, implementation of evidenced-based practices, and the need to become a system informed about and capable of addressing the impact of trauma on the lives of clients.

**Regarding Adult Outpatient Programs:**

Adult Mental Health Outpatient Programs, sometimes referred to as family programs because so may of these adults have children being served by other agency of human services programs, serve more than 7,000 Vermonters a year. The individuals seeking mental health outpatient services typically experience severe dysfunction in family, social, occupational, and self-care roles. Most (53 percent) have marital and family problems and many have histories of psychological trauma that impair current functioning, problems with daily living, social and interpersonal problems, medical and somatic issues, are suicidal and/or abuse drugs and/or alcohol. Adult outpatient programs are not statutorily mandated and have experienced significant erosion of funding and service capacity even in the face of increased demand for these services.

**Regarding Emergency Services:**

Vermonters should be able to receive rapid response and assistance from skilled mental health professionals in times of personal and community crisis. An estimated 7,000 people received emergency services from the public mental-health system in SFY 2004. These services, available 24 four hours a day, seven days a week, serve not only individuals but also communities and organizations that are trying to cope with traumatic or tragic events, such as a natural disaster, homicides or suicides. They include

- 24-hour-a-day telephone support.
- Face-to-face evaluation and referral (mobile crisis team).
- Screening for court-ordered observations in criminal cases.
- Acute care and involuntary assessments (facility based).
- Community liaison with law enforcement, schools, courts, etc.
- Response to community trauma and disasters.

Two important resources for individuals in crisis are crisis stabilization programs and diversion services, which are held to be very effective in reducing hospitalization. They are not distributed evenly around the state, which creates significant issues of access. These programs also are often underutilized.

**Regarding Supported Housing**

Having a place to sleep and a place to live are the most basic requirements of recovery. The able provides data on the level of support provided in 2004. A Futures Committee Work Group on Housing is currently tasked with developing plans to increase the supply of housing units. Table 13 lists supported housing resources available in 2004.

**Table 15**
**CRT Program Housing Inventory [1]**
**Subsidized and/or Supportive Housing**
**October 2004**

| Designated Agency | Adult [2] Population | CRT Clients Served FY '04 | VSH In-House Census Oct. 15 | DMH Rent Subsidy [3] | Group Home Beds | Hospital Diversion Step Down Beds | Other HUD [4] Subsidized DA Supported Beds |
|---|---|---|---|---|---|---|---|
| CMC | 29286 | 169 | 1 | $22,882 | 6 | 0 | 6 |
| CSAC | 27582 | 173 | 3 | $10,331 | 6 | 0 | 18 |
| HCRS | 74818 | 429 | 4 | $29,582 | 18 | 4 | 35 |
| HCHS | 114975 | 671 | 17 | $74,167 | 41 | 12 | 19 |
| LCMH | 18884 | 138 | 3 | $32,490 | 27 | 0 | 0 |
| NKHS | 49441 | 411 | 5 | $16,670 | 3 | 5 | 5 |
| NCSS | 41076 | 250 | 5 | $15,711 | 12 | 0 | 10 |
| RMHS | 50094 | 310 | 4 | $35,882 | 0 | 1 | 19 |
| UCS | 29228 | 192 | 1 | $34,417 | 6 | 6 | 6 |
| WCMH | 46231 | 462 | 3 | $29,664 | 16 | 5 | 5 |
| **TOTAL** | **481615** | **3205** | **46** | **$301,796** | **135** | **33** | **123** |

[1] = Includes housing operated or staffed by Designated Agency provider network.
[2] = Calendar year 2003; adult population of Designated Agency catchment area.
[3] = Housing Contingency Fund.
[4] = Shelter Plus Care.

**16 c The project meets or exceeds appropriate access and quality standards as follows:**

**(1) Short term psychiatric care and psychiatric emergency care will be available to most Vermonters within the geographic areas served by the designated agency system for mental health, substance abuse and developmental services.**

Refer to (8) and (16-b) above. The addition of 10 diversion beds and the strengthening of the Designated Agency System as proposed by Secretary Smith will enhance geographic access to short term and emergency services in all 10 Designated Agency Areas, thereby improving access statewide.

**(2) Psychiatric services in dedicated units will be available to most Vermonters within the hospital service areas for the regional and tertiary hospitals.**

The proposed FAHC – RRMC – Retreat inpatient service design would enhance access. In the primary proposal of this application, FAHC is assumed to provide statewide coverage as a Tertiary Care Hospital, and to provide psychiatric services to residents of northern and western Vermont. The Retreat Health Care serves southern and eastern Vermont while Rutland Regional Memorial Hospital provides psychiatric inpatient services to southern and western Vermont. This dispersion of admission capability from its current central location in Waterbury is planned to advance geographic access for Vermonters who now have only one central location for inpatient care.

**(3) Services provided according to this project will meet the six IOM Aims and have a particular focus on achieving patient-centered (and family-centered) and safe care.**

The following table details how the proposed project will meet the Institute of Medicine Aims (IOM).

| Institute of Medicine Aims[56] | How This Project Addresses IOM Aims |
|---|---|
| 1.Safe: "Patients should not be harmed by the care that is intended to help them" | The current VSH facility can no longer address the important safety issues that arise with patients who have severe mental illnesses. These individuals are among the most vulnerable patients for whom the state is responsible. This project will directly improve the safety measures for the current VSH patients. Replacing the existing VSH facility will provide the appropriate physical space to deliver patient centered services in a safe environment. Improving the physical plant for psychiatric beds at Rutland will allow for improved triage, stabilization and appropriate transfer of patients. These measures will address safety issues and reduce the risk for harm to patients in need of care. |
| 2. Effective: "delivering the best possible care to patients is evidence-based medicine, defined by the Institute of Medicine as "the integration of best research evidence with clinical expertise and patient values." | Current medical literature demonstrates improved health outcomes associated with integrating mental health care with other health care services. The World Health Organization and the President's New Freedom Commission of 2003 emphasize the importance of mental health to overall health, of prevention and early intervention, of having direct services and supports that are driven by those who use them, of simplifying the service system, and of ending disparities in access to care. This national movement of reform also emphasizes evidenced-based practices, the recovery model, and the use of technology to access mental health care and information. In addition, national mental health system reform identifies the importance of integrating substance abuse and mental health service, of understanding the prevalence of trauma, of the unique impact of trauma on people served in human service systems, and of the importance of developing supports and services that are trauma-informed and that support resilience in all individuals, families and communities.<br>Delivering mental health services in partnership with community hospitals is the logical transition for VSH patients to move closer to this integrated model. |
| 3. Patient Centered: "Care that is truly patient-centered considers patients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles. It makes | Patient centered care is best achieved in the context of the communities where patients live. This project will bring the infrastructure and resources necessary for Vermonters in need of mental health services to receive this care in a manner that is more patient centered and community focused than it is today. |

[56] The definitions in this column are from the Institute for Health Improvement website. http://www.ihi.org. See Crossing the Quality Chasm: A New Health System for the 21st Century, Committee in Quality of Health Care in America, Institute of Medicine, Washington, DC, USA: National Academics Press, 2001.

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|---|---|
| the patient an integral part of the care team who collaborates with care providers in making clinical decisions.<br>Patient-centered care puts responsibility for important aspects of self-care and monitoring in patients' hands — along with the tools and support they need to carry out that responsibility" | Integrating needed beds into communities where other health and social services are delivered increases accessibility and decrease stigma for patients and their families. This project will increase opportunities for patient centered team approaches in both inpatient and outpatient settings. Improving care and outcomes for this population requires knowledgeable consumers practicing improved self care, a practice team providing timely planned care, improved information (data), decision support, office systems and supportive community, health care and public health infrastructure. |
| 4. Efficient: "reducing waste of all kinds …effort, materials, medications, money, and trust." | This project by design will determine the best financial option for replacement of the VSH. This determination will maximize the use of state and federal funds in creating VSH replacement facilities. The project calls for financial and architectural expertise so as to avoid waste of effort, material and funds. The project will eliminate the need to continue to restore antiquated facilitates that can no longer serve their purpose and will also improve use of existing space at Rutland and Brattleboro. Patients, families and providers will benefit from a well planned project that addresses patient needs in the most efficient and compassionate manner possible. The planning process has been open and welcoming to all of those with an interest in mental health services and willing partners have come forward to work together on a statewide approach. |
| 5. Timely : Eliminating non-instrumental waiting, waiting that no one intends or that doesn't carry any information with it…. less waiting in our system —appropriate waits and the avoidance of harmful delays for both patients and those who give care — | Organizing mental health care services according to levels of care with tertiary level care at Vermont's only tertiary care hospital and improving services at Rutland Hospital will improve triage, stabilization and appropriate transfer of patients. This approach supports a patient centered model that promotes and facilitates timely health care services. Prompt triage and efficient placement according to need not only avoids potentially harmful delays but also may help avoid unnecessary hospitalizations that can be the result of delayed interventions. |
| 6. Equitable: "provide care of equal quality to everyone, regardless of race, age, gender, ethnicity, income, geographic location, or any other demographic detail." | A review of the Vermont hospitalization rates for adults with serious mental illnesses from 2002 reveals that the counties with the highest rates are Rutland, Washington, Windsor, Windham and Orange counties.<br>( HRAP Table 17 page 47)Inpatient treatment programs to these regions will be enhanced under this proposed project. Additionally, improved triage and appropriate transfer capabilities will promote the most appropriate care in the least restrictive setting in a timely and equitable manner. Accessibility to higher quality services is improved with a community based system of care that provides services across the continuum. |

**16 c(4) Services for this project meet unmet needs in Vermont as follows:**

This table uses references from the Futures Reports provided in the Appendix and References of this application.

| Unmet Need in Vermont | Project description addressing unmet need |
|---|---|
| **i. Mental health, psychiatric and substance abuse services, particularly for children and adolescents;** | The scope of this plan is limited to adults. |
| **ii. Access to intensive outpatient programs;** | Residential programming in this plan addresses the needs of individuals who need intensive rehabilitation, but do not need to be hospitalized. Specifically, this plan proposes to create two new such programs designed to meet the needs of a longer term care population currently at VSH but who do not need inpatient level care. These programs include residential recovery programs for sub acute rehabilitation and secure residential treatment. The Vermont Mental Health Futures Plan proposal presented to Legislative Mental Health Oversight Committee March 22, 2006. Approved by the Committee April 25, 2006. Page 3 |
| **iii. Access to partial hospitalization programs;** | Residential recovery programs are designed to meet the needs of individuals who have experienced repeated hospitalizations or extended stays at VSH. These individuals have a slow response to treatment and multiple disabling conditions. Individually focused rehabilitation programs in non-institutional settings will assist this population in making gains to recovery. The current VSH environment is fundamentally institutional. The new intensive programs under the VSH replacement plan will allow intensive outpatient programming. The Vermont Mental Health Futures Plan presented to Legislative Mental Health Oversight Committee March 22, 2006. Page 3 |
| **iv. Improved treatment for suicidal patients;** | Improved care for suicidal patients will occur in new inpatient capacity as proposed for FAHC, RRMC and Retreat Health Care. Vermont State Hospital Futures Plan Report to Charles P. Smith, Secretary of Human Services, February 4, 2005. Page 26 |
| **v. Improved education and support for primary care providers, and better integration of primary care and mental health;** | This plan calls for continuation and expansion of work currently being done with primary care physicians and their staffs particularly in the areas of diagnosing and treating depression and making referrals to appropriate specialized services. The Vermont Mental Health Futures Plan presented to Legislative Mental Health Oversight Committee March 22, 2006. Page 5 |
| **vi. Improved care for people with co-occurring disorders** | Programming for individuals with co-occurring disorders will be provided within the VSH replacement services. The approach uses appropriate teams of mental health and substance abuse providers. Additionally, collaboration between the Department of Corrections and the Department of Health divisions of mental health and of alcohol and drug abuse programs provides an opportunity to use evidence-based integrated mental |

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| | health and substance abuse treatment approach to provide outpatient treatment to severely ill and addicted offenders. Staff teams from corrections, mental health clinicians and substance abuse clinicians allow for community and group treatment and reduce the risk of re-offense, hospital care, and most importantly create the best opportunity for positive recovery results. The Vermont Mental Health Futures Plan presented to Legislative Mental Health Oversight Committee March 22, 2006. Page 5 |
| **vii. Access to opiate addiction treatment;** | Although fundamental to a comprehensive mental health system, opiate programs are provided through the Division of Substance Abuse Services and not directly addressed in this CON. Coordination of mental health and substance abuse treatment is a primary objective of the Futures Plan. Recommendations for the Future of Services provided at the Vermont State Hospital, February 4, 2005. Page 3 |
| **viii. Availability of outpatient services in order to decrease the demand for more costly emergency and hospital based care;** | Fundamental to this plan is supporting infrastructure and programs for community mental health services. The transformation of community based and peer services into a voluntary and upstream system of supports and services will ultimately reduce Vermont's reliance on psychiatric inpatient care and involuntary care. Appropriately placing the services geographically will ensure the widest access to continuum of care services that support recovery. The Vermont Mental Health Futures Plan presented to Legislative Mental Health Oversight Committee, March 22, 2006. Page 4 |
| **ix. Sufficient mental health and substance abuse prevention, screening and aftercare services;** | This plan includes a care management program to ensure that the system can manage and coordinate access to the appropriate level of care and to maximize utilization of the systems resources. The care management function will provide access to outpatient care and community reintegration following inpatient treatment. Substance abuse prevention and screening will also occur through continued efforts with primary care providers. Also envisioned in the new system of care is the capacity to provide service for individuals transitioning to outpatient care and permanent housing. Persons in this step-down program would typically begin the program upon release from a hospital and would be discharged at the end of their stay. The Vermont State Hospital Futures Plan, February 4, 2005. Page 31 |
| **x. Access to residential care;** | The full Futures plan calls for the creation of new residential and housing services. Not reviewed in this application but an essential component of the reorganized delivery system. |
| **xi. Peer recovery services;** | Peer programming offers effective recovery oriented supports. The importance of peer support and meaningful peer involvement in the mental health service system is critical to promoting resilience and recovery. Within the programs envisioned in this plan are new peer support programs targeted to individuals who use VSH. Peers also will be an integral part of traditional and new services. Current programs provided by Vermont Psychiatric Survivors and others will be continued and the expansion of additional standalone peer services will be explored with and eye towards identifying evidence based best practices. The Vermont Mental Health Futures Plan presented to Legislative |

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| | Mental Health Oversight Committee, March 22, 2006. (The Vermont State Hospital Futures Plan February 4, 2005. Page 23 |
| **xii. Suicide prevention programs;** | Not reviewed in this application but an essential component of the full continuum of health services. |
| **xiii. A full range of community-based treatment and support;** | Not reviewed in this application but an essential support component of in-patient psychiatric services and included in the complete Futures Plan. |
| **xiv. Affordable housing options;** | Not reviewed in this application but an essential component of community support services and included in the complete Futures Plan. |
| **xv. Substance abuse primary prevention efforts;** | Not reviewed in this application but an essential component of the full continuum of health services. |
| **xvi. Safe and sober housing for people in recovery;** | Not reviewed in this application but an essential component of the larger delivery system and included in the complete Futures Plan. |
| **xvii. Increased peer-operated programs for mental health recovery;** | Peer programs provide effective recovery oriented supports. New peer programming is integral to targeting and expanding opportunities for successful recovery and are integral to this plan. The Vermont Mental Health Futures Plan presented to Legislative Mental Health Oversight Committee, March 22, 2006. Page 14 |
| **xviii. Diversion programs to effectively avoid admissions to the VSH successor facilities;** | Diversion programs will be augmented to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization. Enhancing capabilities, particularly at Rutland, will improve the ability for effective triage and stabilization. The Vermont Mental Health Futures Plan presented to Legislative Mental Health Oversight Committee, March 22, 2006. Page 14 |
| **xix. Supports effective services to reduce the number of VSH successor beds;** | The strategy for replacing services currently provided by the Vermont State Hospital under this plan are developed within the context of long range planning for a comprehensive continuum of care for mental health services. Under this plan the current capacity of fifty-four beds would be preserved, but the beds are more appropriately distributed among programs offering different levels of care and greater local access to many services. The systems capacity is strengthened with diversion programs that will limit what would otherwise be increasing need for more impatient beds. The ICU and SIP services that would be available at FAHC provide for integrated services at appropriate levels of care. Increased services that will be available through Rutland will improve triage, stabilization and appropriate transfer of patients. Vermont State Hospital Futures Plan presented to Legislative Mental Health Oversight Committee, March 22, 2006. Page 20 |
| **xx. Maintains current level of local capacity and supports necessary increases in existing facilities;** | This plan to replace the VSH facility will maintain current level of local capacity at all of the Partner institutions and will enhance capacity with intensive and specialized programs. The recommendation for increased inpatient beds is derived from analysis of current capacity, past utilization, and projected impact of new residential programs to reduce the VSH census. |

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|---|---|
| | This projection is based on analysis for ten years into the future statewide. The analysis considers the impact of Vermont's community based system of care for mental health services including the development of new programs. It also considers the needs for psychiatric and inpatient beds for the Department of Corrections. The Vermont Mental Health Futures Plan presented to Legislative Mental Health Oversight Committee, March 22, 2006. Pages 11-15 Actuarial study of the needed bed capacity for Adult Mental Health Inpatient Services, Milliman, June 2, 2006. |
| **xxi. Appropriate addition of beds to local community hospitals;** | It is projected that the preferred option of additional beds at FAHC, renovations to the existing unit at Rutland, and additional beds at Brattleboro will maintain current levels of capacity and support necessary increases in existing facilities. Increasing capacity in these three locations additionally provides for greater geographic access. The Vermont Mental Health Futures Plan presented to Legislative Mental Health Oversight Committee, March 22, 2006. Pages 11-12 |
| **xxii. Capacity in therapeutic community residences are maintained and supported so as to assure appropriate levels at VSH successor institutions;** | This plan supports therapeutic community residences and programs across a full continuum of care. Non-hospital based care will be provided through sub acute and diversion programs so as to provide the most appropriate level of care for those in need. The Vermont Mental Health Futures Plan presented to Legislative Mental Health Oversight Committee, March 22, 2006. Page 3. The Vermont State Hospital Futures Plan, February 4, 2005. Pages 28-31 |
| **xxiii. Establishes or maintains linkage agreements with organizations providing mental-health care in the community to assure a coordinated system of care that allows access to the appropriate level of care.** | Multiple linkage relationships and collaboration agreements with other organizations providing mental health care in the community is critical to the success of a system that assures a coordinated system of care allowing access to appropriate levels of care. The Department of Mental Health is committed to establishing these important key agreements and has begun this work with FAHC, Rutland Regional Medical Center, and Retreat Health Care. Additional discussions are underway with key community providers. Addressing the financial and clinical issues will require significant enhancement of the relationships among general hospitals, VSH and the community providers. Because the current facility is antiquated and does not conform architecturally to current inpatient standards, it must be closed. The closing of VSH gives Vermont a rare opportunity to establish a state-of-the-art intensive care program. |

## B. HRAP Criterion 3

**There is an identifiable, existing need for this project which is appropriate for the Department of mental health to provide.**

The identifiable existing need to replace the Vermont State Hospital is without question. The need to continue to provide the services and programs that are currently provided for at VSH is also without question. This conceptual CON is necessary to further plan for most clinically appropriate and financially feasible option(s) for accomplishing this directive. The specific Authorization for Futures Planning is found in the Vermont State Statutes.

**Specific Authorization for Futures Planning**
Section 141a of the Appropriations Bill of 2003-04 charged the Secretary of Human Services with "development and, upon approval by the mental health oversight committee and joint fiscal committee, implementation of a comprehensive strategic plan for the delivery of services currently provided by the Vermont state hospital . . . ." See 2003-04 Vt. Acts & Resolves 122, An Act Making Appropriations for the Support of Government, § 141a(b) (the "Big Bill"). To assist the Secretary in this process, the Legislature created the Vermont State Hospital Future Planning Advisory Group (the "Futures Advisory Group"). See id. The Bill directs the Secretary, following consultation with the Futures Advisory Group, to provide the Legislature's Mental Health Oversight Committee and Joint Fiscal Committee, "a report containing a comprehensive implementation plan for replacing the services currently provided by the Vermont state hospital . . . ." Id. at § 141a (i). This report is to include proposals for legislation and capital and operational funding needed to implement the plan." Id.

Section 141c of the Big Bill created the Legislature's Mental Health Oversight Committee (the "Oversight Committee") to "oversee the development and implementation of the secretary of human services' strategic plan to develop alternatives for services currently provided by the Vermont state hospital . . . ." See id. at § 141c. The Oversight Committee is charged with reviewing and approving, modifying, or disapproving the Secretary's recommendations with respect to replacing Vermont State Hospital. See id. at § 141c (b)(4).

The Big Bill expressly directs the Secretary of Human Resources to implement the futures plan "upon approval by the mental health oversight committee and joint fiscal committee." See id. at § 141a (b). A more recent appropriations bill specifically "adopts the principles in the May 31, 2005 report from the department of health for restructuring the delivery of mental health services currently received in the Vermont state hospital . . . ." 2005-06 Vermont Acts & Resolves 71, Making Appropriations for the Support of Government, § 113e (a). This includes replacing VSH "with a facility or facilities with fewer than 54 beds and with meaningful programmatic integration of medical and community mental health services." Id. When the Legislature is not in session, DMH is directed to obtain approval "on specific programmatic recommendations, plans, or implementation steps to achieve the principles in the May 31, 2005 draft report prior to implementation." Id.

## C. HRAP Criterion 4

**This project will improve the quality of health care in the state and will provide greater access to health care for Vermont's residents.** The Vermont State Hospital was designed almost seventy years ago in an era in which the major treatment modalities were work and respite in a pastoral setting. Current standards for inpatient care require active treatment – medical, psychiatric, and psycho-social – by multi-disciplinary teams. The facility is old and there is concern with safety, security and control issues. Observations and inspections have identified many areas of problems with respect to the building. The physical structure impedes a diligent and caring staff from providing the highest quality of care possible. This plan will provide for facilities that promote a therapeutic environment and will provide greater access to Vermont residents in need of mental health care. Additionally, this plan moves Vermont closer to the ideal setting for mental health services that provides those services across a continuum of care that merges mental health care with other services including medical services. Some of the specific physical problems with the current VSH facility that will be remedied by this plan include the following:

1. The over-all environment of the hospital does not meet the current therapeutic standard
2. The facility was built in an era that does not address a therapeutic environment that utilizes institutional materials and construction methods.
3. The architecture is more like a correctional facility than a therapeutic health care facility with controlled spaces.
4. Patient bedrooms do not meet the current standards for size and appointments and lack private bathrooms.
5. Patient bathrooms are accessed down long corridors, providing a control problem and areas for patient hiding places
6. The seclusion room does not meet the current standard.
7. The hospital lacks appropriate visiting space.
8. There is no appropriate space for individual or group treatment meetings.

Implementation of the VSH replacement plan approved through this Conceptual CON will remedy current physical plant problems and permit programming that integrates mental health with other health services. Care will be patient-centered and individualized with the greatest opportunity for recovery. Programming will incorporate the IOM aims as discussed above and will emphasize the importance of mental health to overall health. Geographic access will be improved as will the ability to provide services in the least restrictive setting and the most integrated fashion possible.

## D. HRAP Criterion 6
**This project will serve the public good**

- **In this application the Futures Project proposes to provide services to individuals when they are most vulnerable in an environment that physically matches the therapeutic intent of those who seek to help them. The measure of the values of a society is how well we provide for those who, for whatever reason, are unable to provide for themselves. This project will serve the public good by** moving Vermont further towards its vision of deinstitutionalizing its programs and improving outcomes for persons with mental illness. Clinically appropriate care across a broad continuum of services is the cornerstone to an effective health care system. This plan proposes to establish an infrastructure that

ensures this full continuum of services in the most integrated and least restrictive environment, and to incorporate the needs of certain populations served by the Department of Corrections. Recognizing that the existing VSH IMD model for provision of inpatient care is not economically viable and more importantly that the provision of psychiatric inpatient services in a stand-alone IMD is not consistent with Vermont's policy of integrating mental health and general health care services, this conceptual CON is critical to improving mental health care services in Vermont. The conceptual CON will provide the best opportunity to further study and evaluate preferred options for a system that provides comprehensive mental health services to Vermont residents in need. It will serve the public good by identifying the most appropriate plan for economically replacing services currently provided at VSH with a state of the art system that maximizes the opportunity for recovery.

**Conclusion**

It is without doubt that the VSH current facility must be closed and appropriate replacement planning is necessary. The time for responding to Vermonters in need of mental health services is overdue. Creating a system that integrates mental health services with other services including medical services will provide the best opportunity for care in the least restrictive setting and maximize the opportunity for achieving recovery. Partnering with willing community providers enhances clinical quality and economic efficiencies.

The options under review in this application are the result of multi-stakeholder study and input. While not conclusive, they have been identified as the preferred options for further study. Although this application specifically, proposes to primarily assess the preferred following configurations and plan for the arrangement(s) that emerges as the best clinical and financially feasible model, other options will be considered should they arise in the course of planning. While remaining open to alternatives, the heart of this conceptual CON , is to request permission to incur planning expenditures to analyze and compare the feasibility of the various options for this project that are under consideration.

The primary CON question that is under review is whether the Vermont Division of Mental Health should be permitted to incur planning expenditures to analyze and compare the feasibility of various options for the replacement of the Vermont State Hospital.

**APPLICANT NAME**
**PROJECT NAME**

# Required Tables

When completing the tables please note that you need only fill-in the **shaded fields.** Fields with diagonal lines indicating **N/A** do not require an entry. The CON Application Form tables, when completed electronically, are set up to calculate totals as well as pre-populate fields in other tables for you. If you have any questions please contact Division staff. Also, please contact Division staff prior to determining if a given table may not be applicable for your project.

Applicants are encouraged to submit an electronic version of a completed application via attachment to email. Please send electronic versions as attachments to email addressed to: **jgarson@bishca.state.vt.us**

| Table | Description |
|---|---|
| 1 | Project Costs |
| 2 | Debt Financing Arrangement: Sources & Uses of Funds |
| 3A | Income Statement: Without Project |
| 3B | Income Statement: Project Only |
| 3C | Income Statement: With Project (no 'fill-in' required) |
| 4A | Balance Sheet - Unrestricted Funds: Without Project |
| 4B | Balance Sheet - Unrestricted Funds: Project Only |
| 4C | Balance Sheet - Unrestricted Funds: With Project (no 'fill-in' required) |
| 5A | Statement of Cash Flows: Without Project |
| 5B | Statement of Cash Flows: Project Only |
| 5C | Statement of Cash Flows: With Project (no 'fill-in' required) |
| 6A | Revenue Source Projections: Without Project |
| 6B | Revenue Source Projections: Project Only |
| 6C | Revenue Source Projections: With Project (no 'fill-in' required) |
| 7 | Utilization Projections: Totals |
| 8 | Utilization Projections: Project Specific |
| 9 | Staffing Projections: Totals |

**Notes Related to the Conceptual Certificate of Need Financial Tables**

Please note that based on the specific instructions of BISHCA staff revenue, expenditure, utilization and staffing information is based on FY 2006 actual data for the current Vermont State Hospital unless otherwise noted below. The capital construction and renovation cost ranges are only preliminary and are not endorsed by any of the proposed inpatient partners. The notes below provide additional detail to the financial tables. Please use these notes as a guide to the financial tables.

Table 1 – Project Costs: The construction and renovation estimates reflect a range of theoretical costs for the primary inpatient program. The facility sizes were developed as the basis of design from the early planning information. Future operational decisions and detailed plans should narrow the range of theoretical costs for each scenario. The cost ranges for the three different program approaches for the primary inpatient program are detailed below:

- **40-bed stand alone facility.**
  Stand alone facilities require larger square footage than integrated units because all the functions of a hospital need to be created for that facility (kitchen, admissions, administration and so forth.).

  Theoretical cost range: $43 – $58.5 million

- **40-bed integrated facility.**
  This design allows for less square footage because the host facility provides some of the functions. However, on the FAHC campus a program attached to the inpatient core will likely require more site development costs including replacement parking.

  Theoretical cost range: $46.5 – $60 million

- **68-bed integrated facility.**
  This design incorporates the existing 28-bed program that FAHC currently operates with the 40-beds to replace VSH. It also reflects the higher site development costs of the integrated options.

  Theoretical cost range: $69 – $86 million

The integrated models do not reflect the costs of any infrastructure improvements to the host hospital that may be required in order to service the new beds.

Design for the secondary program at Rutland Regional Hospital has considered various floor plan options, all of which involve expanding into space adjacent to the existing psychiatric inpatient unit and re-working the floor plan of the current unit. This may allow for better use of the existing bed capacity and for more flexibility for the provision of various levels of care.

- Renovation could add 6 new beds to the licensed 19 resulting in a total capacity of 25. The preliminary layout provides for a 13-bed locked unit, a 5-bed open unit, and a 7-bed locked unit with more intensive security and support. RRMC's current occupancy is limited to an average daily census of 10-12. This renovation will allow for sufficient program space to utilize all 25 beds, thus adding 10 – 12 more acute beds to the system.

Theoretical cost range: $7 - $13.4 million

Table 2 – Debt Financing Arrangement, Sources & Uses of Funds: Though specific project financing has not been determined at this time, in general, Vermont uses the following methods to finance capital projects:

- Bonded funds through the Capital Construction bill
- General funds
- Private developer – lease back

Table 3A – Income Statement without Project: The revenues are based on the FY 2006 Legislative appropriation for the Vermont State Hospital. The inpatient care revenue consists of general funds ($16,596,320) and an interdepartmental transfer from the Vermont Department of Health – Mental Health ($450,000). The other operating revenue represents the canteen fund at the Vermont State Hospital ($225,182).

Operating expenses are based on FY 2006 actual expenses incurred by the Vermont State Hospital. Fringe benefits include FICA, health insurance, dental insurance, retirement, life insurance, long-term disability insurance, employee assistance program, employee clothing allowance, tuition, workers compensation and unemployment compensation.

Table 4A – Balance Sheet – Unrestricted Funds without Project: The Vermont State Hospital does not have liabilities or most types of assets. It does have a small amount of equipment. These figures are provided in Table 4A. The Vermont State Hospital operates within its appropriation.

Table 5A – Statement of Cash Flows without Project: This table is not applicable to the Vermont State Hospital as it does not have investing or financing activities.

Table 6A – Revenue Source Projections: The Vermont State Hospital receives most of its revenues through the State Legislative appropriation process. The gross inpatient revenue – other category includes general funds ($16,596,320) and an interdepartmental transfer from the Vermont Department of Health – Mental Health ($450,000). The gross other revenues – other category consists of the canteen fund at the Vermont State Hospital ($225,182).

Table 7 – Utilization Projections Totals: With one exception, these figures are based on FY 2006 actual data. The average length of stay is from FY 2005.

Table 8 – Utilization Projections Project Specific: These figures are based on FY 2006 actual data.

Table 9 – Staffing Projections Totals: Total general services non-MD FTEs include the Admissions office and administrative staff. Total Inpatient Routine services non-MD FTEs include psychiatric technicians, pharmacy staff, dietary staff, social workers and a psychologist. Physician FTEs include a physician, psychiatrists (on-call as well as regular), a medical director, a neurologist, and a psychiatry resident/fellow. The direct service nurse FTEs include both RNs and LPNs. Staffing needs for new replacement options are likely to increase. These needs will be identified in the Phase II CON planning process.

Click here to see Tables 1-9

# Appendix A

## Request for Information
## Regarding Possible Partnerships
## in a Transformed Mental Health System

## December 16, 2004

VERMONT

**Department of Health**
Division of Mental Health [phone] 802-241-2610
103 South Main Street • Weeks Bldg. [fax] 802-241-1129
Waterbury, VT 05671-1601 [tty] 800-253-0191
**www.HealthyVermonters.info**

*Agency of Human Services*

## Request for Information Regarding Possible Partnerships In a Transformed Mental Health System

Draft - December 16 2004

The Vermont Department of Health (VDH) is seeking partners to operate a continuum of recovery-oriented, community-based services including peer supports, acute non-hospital diversion programs, inpatient services including psychiatric intensive care, and sub acute rehabilitation services. This array of services will allow for the replacement of the Vermont State Hospital (VSH) as it is currently configured. All types of mental health service providers[1] are encouraged to respond to this Request for Information (RFI).

The objective of this RFI is to obtain information about partners to implement these services. Respondents should describe their capacity and interest to provide all or some of the specific service components in this RFI. This RFI is not a contract, implicit, explicit, or implied, nor does it imply any form of an agreement with any party. Responses to this RFI will be considered in drafting any Requests for Proposals for VSH replacement services.

The information gained from this RFI will be presented to the Vermont State Hospital Futures Advisory Group and to the Secretary of the Agency of Human Services (AHS). The responses will help inform the Secretary's recommendations on replacing the functions of Vermont State Hospital to the Mental Health Oversight Committee of the Vermont Legislature in January, 2005.

**Please submit your response to this RFI in writing by the close of business on December 31, 2004 to:**

Susan Wehry, MD
Deputy Commissioner of Health for Mental Health Services
Vermont Department of Health
108 Cherry Street
PO Box 70
Burlington, Vermont 05402-0070

Electronic responses directed to WRichardson@vdh.state.vt.us and received before the deadline shall be accepted, as shall mailed responses postmarked on or before the deadline.

[1] This includes hospitals with and without designated psychiatric inpatient units, designated community mental health providers, private mental health providers including residential and single or group practices, and advocate/peer service providers.

This RFI seeks information about the capacity and interest of partners for five distinct service components. ***Interested parties may respond to this RFI in its entirety or to any number or combination of the following components****:*

- Peer support programs.
- Crisis stabilization/hospital diversion services.
- Acute inpatient care (involuntary) for civil and forensic admissions.
- Sub acute, longer term psychiatric rehabilitation services.
- Secure residential care.

## Context for Replacing VSH Services

Replacing the current functions of Vermont State Hospital offers the opportunity to make new progress towards Vermont's continuing development of voluntary, community based services. However, VSH[2] currently provides the following safety net functions that are not duplicated by any other entity, and for which short and longer term replacement strategies may be required:

- A "no decline" admission policy.
- Acute, involuntary, inpatient treatment for individuals currently not able to be treated by designated[3] community hospital psychiatric units (by direct admission: 77 admissions in FY 2004; by transfer, 31 admissions in FY 2004).
- Provision of longer term (longer than one month), involuntary care for individuals with treatment refractory illnesses (60 percent of the bed days at VSH currently).
- Evaluation and inpatient treatment for individuals charged with a crime, also known as forensic evaluations (103 admissions in SFY 04).
- Provision of non-emergency involuntary psychiatric medication under Vermont's Act 114[4] (27 petitions filed in SFY 04).

The replacement functions for VSH, even in a transformed system of care, must address these aspects of a bottom-line responsibility for care. VDH believes that the current capacity at VSH, in community hospitals and with community mental health providers could be re-balanced across an array of inpatient, rehabilitation, and enhanced community resources to better meet the needs of Vermonters. This emerging array of inpatient, rehabilitation, and enhanced community resources must have sufficient "surge capacity" to meet expected spikes in demand, and must function in a coordinated and statewide manner to accommodate the flow of patients across resources based on clinical needs.

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[2] The Vermont State Hospital is currently licensed to operate 54 beds. In state fiscal year 04, VSH had a total of 219 admissions accounting for 18,963 patient bed days with an average daily in-house census of 46 individuals. Neither the Vermont Department of Health nor the Vermont State Hospital Futures Advisory Committee recommends a reduction in the overall system's bed capacity.

[3] A designated hospital is a general hospital with psychiatric inpatient services that is designated by the Commissioner of Health (formerly by the Commissioner of Mental Health) to provide treatment to individuals involuntarily committed to the commissioner's care and custody.

[4] Act 114 sets out clinical and legal standards, and the process for providing non-emergency psychiatric medications on an involuntary basis in a hospital.

In addition, AHS needs a psychiatric inpatient program capable of safely treating acutely ill and potentially dangerous individuals who are committed to the care and custody of the Commissioner of Corrections. This service would not be located within a correctional facility. [Neither the Department of Corrections (DOC) mental health units nor the VSH, as currently configured, is able to appropriately serve such individuals.] The DOC estimates that there are eight individuals at any given time in need of such services.

In choosing replacement services within the context of an evolving mental health service system, VDH will be guided by the following goals:

- To fully integrate the functions of VSH into local health care and community mental health (designated agency[5]) systems.
- To further the commitment to the principle of maintaining the locus of care in the community.
- To ensure that provided services are recovery oriented and trauma informed.
- To reduce the use of and need for involuntary care of all types, including inpatient.
- To ensure that all people with psychiatric disabilities, including those who are incarcerated, shall have access to high quality, clinically appropriate care across a broad continuum of services.

## Guidance for Respondents to this RFI

Respondents to this RFI should describe how their proposed concepts for replacement services address the safety net functions and system goals listed above. In addition, respondents should address the following requirements common to all of the five service components:

- Geographic accessibility and decentralization of services. Multiple-site proposals are encouraged.
- Meaningful integration with general health care delivery is required.
- Meaningful integration with ongoing mental health care and community life is required.
- Patient access to adequate legal protections. Respondents should demonstrate knowledge of current Vermont law regarding patient's rights generally and involuntary care in particular.
- Programs and facilities must be flexible enough to accommodate future changes in treatment practices.
- Surge capacity is a necessary requirement of this system of care.
- Participation in a process of triage and placement involving other system components is required.
- Each service component must be capable of identifying and effectively treating conditions that commonly co-occur with mental illness and among individuals seeking

[5] A designated agency is a community mental health center designated by the Commissioner of Health (formerly by the Commissioner of Mental Health) as the lead agency to provide comprehensive services to Vermont's priority mental health populations: adults with severe and persistent mental illness, individuals with developmental disabilities, and children and youth with severe emotional disturbances.

acute treatment including trauma, substance abuse, developmental disabilities, traumatic brain injury, and health problems.
- How both civil and forensic patients might be served.
- How the proposed approach to services would reduce the current demand for involuntary inpatient care.

Respondents to this RFI should describe their interest in and capacity to provide all or parts of the proposed service components. Finally, respondents are especially encouraged to address considerations that are not included in this RFI but which respondents believe should have been included.

## Specific Service Components

### 1. Blended Peer Support Programs

In keeping with the vision of a community-based system in which all services are recovery-oriented, VDH is seeking both potential partners and design concepts for blended peer and provider service approaches. We are interested in how blended staffing in a wide variety of supports and services can support people in recovery and divert individuals in crisis from entering the hospital. We are interested in hearing potential partners' ideas about how to develop such resources and about more specific program characteristics for the following proposed components:

- Education and support resource centers.
- Crisis stabilization and inpatient diversion services.
- Sub acute rehabilitation services.
- Services that assist with the transition to community living.
- Approaches that reduce rates of involuntary care (both inpatient and community).

### 2. Acute Triage, Inpatient Diversion, and Crisis Stabilization (Capacity of 10 or more beds)

Triage, inpatient diversion and crisis stabilization services are needed. VDH is seeking both potential partners and design concepts. This need includes:

- An additional 10 or more crisis stabilization beds designed to divert inpatient admissions, to reduce length of stay for hospital care by offering a step-down[6] services and to provide a safe and supportive environment in which to assess what level of care is needed.
- Centralized care management capacity to manage the flow of clients among acute care programs, including entry into the system and disposition to appropriate levels of care.
- Safe and respectful transportation between acute treatment and stabilization program sites.

[6] Step down means intensive, short term residential or partial hospital programs to provide treatment and facilitate return to the community from inpatient care.

### 3. Involuntary, Inpatient Care (Capacity of 40 beds)

Psychiatric intensive and specialized inpatient care services are needed. This need includes acute care units for persons with mental illness whose behavior places themselves or others at very high risk for harm.

- 32 beds to replace existing VSH capacities.
- 8 beds to provide acute inpatient care for incarcerated individuals.

Two linked services are needed: a small (estimated 8-10 bed capacity statewide), intensive care program modeled after a medical intensive care unit (ICU), and a less intensive but specialized inpatient program (SIP) (30-32 beds statewide; ideally in two or more locations).

These services would have more security, specialization, and staffing than current Designated Community Hospital psychiatric units. Each service would work in concert with the designated hospital units, however, to triage patients across inpatient settings based on clinical considerations. These services would not turn away eligible admissions. These linked services (psychiatric ICU and SIP) should be provided in meaningful physical proximity to a general hospital and probably would contract for the sharing of diagnostic, lab, laundry, food or other required facility services.

- The needed 40 bed capacity (including ICU) can be provided in a single facility or in multiple, decentralized program sites.
- The inpatient capacity could be state-operated (if fewer than 16 beds), operated under the license of an existing hospital, or by a combination of such arrangements.
- Psychiatric inpatient beds would need to be less than 50% of a hospital's daily census to allow for participation in federal Medicaid.
- The service(s) must have the capacity to provide involuntary care, treat forensic clients, and administer non-emergency involuntary medications under the terms of Act 114.

### 4. Sub Acute Rehabilitation Care (Capacity of 16-20 beds)

Sub-acute psychiatric rehabilitation services with a 16-20 bed capacity statewide are needed. This component will provide intensive rehabilitation services to individuals requiring longer-term support but not inpatient-level care. As envisioned, this program would establish a new level of rehabilitation programming in Vermont's mental health service system. The capacity that would be provided by this component would be somewhat like that of physical rehabilitation programs in which individuals adjusting to catastrophic illness or injury receive intensive services to consolidate the gains made in inpatient care and to develop new skills to facilitate adjustment to their home environment. The programmatic orientation and staffing for this service should significantly reduce the need for involuntary treatment. Currently, all the residents of the VSH "Brooks Rehabilitation Unit" are involuntarily committed to the VSH. A more decentralized, community-based, and recovery oriented rehabilitation approach may mitigate the need for involuntary treatment.

- The needed 16 to 20 bed capacity can be provided in a single facility or in multiple, decentralized program sites.
- The program(s) must be state-wide resources operating in collaboration with inpatient treatment and ongoing community care.

### 5. Secure Residential Care (Capacity of 6 beds)

Secure residential services in a community setting are needed. This service component will provide long-term services to individuals who are psychiatrically stable, who have committed serious crimes and who are in the care and custody of the commissioner. This residential program would provide supervision to ensure community safety, and the community's confidence in safety would be a high priority. The need for these services could be fulfilled by a single unit or by provision of wrap-around[7] services for individuals in separate locations.

[7] A wrap-around plan is the generic term for an intensive, individualized program of care, usually including support and supervision 24 hours a day. Each program is created for one person, based on that person's unique needs and strengths.

# RESPONSES FROM THE RFI

12/22/04

Susan Wehry, MD
Deputy Commissioner for Mental Health Services
Vermont Department of Health
108 Cherry St.
PO Box 70
Burlington, VT
05402-0070

Dear Dr. Wehry:

I am writing on behalf of the Counseling Service of Addison County in response to the RFI for the VSH Futures process. Our agency has been very interested in the Futures process and in the possibilities for innovation and improvement that this process invites. We are deeply committed to as complete a spectrum of integrated community based care as can effectively be developed and sustained, and to the values of respectful, effective, recovery informed care in the least restrictive environment needed. We are interested in participating in the Futures process especially in regards to strengthening our existing resource base of housing and crisis supports, and we believe that we could develop capacities that would reduce use of involuntary hospitalization. We are developing proposals to create capacities for Inpatient Diversion, Crisis Stabilization, and Sub Acute Rehabilitation for consumers in the Vermont system of care. We are also looking at possibilities to incorporate blended peer support into these or separate proposals.

The Counseling Service would bring to these proposals our commitment and values in regards to quality consumer driven services. We have consistently strong DBT and Recovery programs, a long standing commitment to welcoming, integrated co-occurring disorders services, and strong psychiatry and emergency teams. We are a comprehensive community mental health center with expertise and services for consumers who are coping with other conditions in addition to mental illness, including substance abuse, developmental disabilities, and trauma.

Given holiday schedules and the deadline for this RFI, we are unable to provide as much detail regarding these possibilities as would be desired for this stage of the process. Our initial thoughts are as follows:

- Long term supported housing has been identified as a priority need in our system of care. The development of such housing could allow for possible placement of VSH patients, and could take some capacity pressure off of Hill House which has had to serve needs that go far beyond its original design as a transitional residence.
- We are further considering proposing that Hill House develop recovery oriented programming, increase crisis stabilization capacity, and function as a transitional residence, step-down, and stabilization program that could have some capacity for subacute rehabilitation referrals from the broader system of care.
- In addition to increased crisis stabilization capacity and services at Hill House, we are also seeking to further develop flexible outreach stabilization teaming, informed by the ACT model. We believe that these capacities would reduce the need for involuntary interventions.

- We are considering further whether to develop a larger scale proposal for acute stabilization and/or subacute rehabilitation, especially as there are some compelling buildings available in Addison county.

We welcome the opportunity to participate in the further development of community based services in the Futures process.

Sincerely,

Alexander Smith
Director, Community Rehabilitation and Treatment Program

**Community Rehabilitation and Emergency Services**
United Counseling Service of Bennington County, Inc.
100 Ledge Hill Drive, PO Box 588
Bennington, Vermont 05201
Phone: (802) 442-4968 Fax: (802) 447-1181

# Response to Request for Information Regarding Possible Partnerships In a Transformed Mental Health System

United Counseling Service of Bennington County, Inc. would like to reply to the RFI issued by the Division of Mental Health on December 16, 2004.

The CRES Division of UCS is organized to provide the type of services essential to address the gaps in the public mental health system as it is currently configured and as anticipated through a reorganization of the function and services of the Vermont State Hospital. As the state hospital is reorganized delegation of a substantial portion of the safety net currently provided by VSH will be passed to the local and regional communities of Vermont. UCS serves the southwestern region of the state. Currently there are no inpatient psychiatric hospital beds in this area.

## Crisis Stabilization/hospital diversion services

UCS provides crisis intervention, crisis stabilization and hospital diversion services through programs operated out of Battelle House. Battelle House provides six acute care diversion beds. These beds are available regionally to assist those in need of hospital diversion across the southern portion of the state.

The use of beds at Battelle House varies widely over time. For example, in March of 2004, bed use was at 89% of capacity; in April usage went down to 47.7% of capacity; and then in May usage rose to 91.2% of capacity. Currently we are at 47.4% of capacity (12/01/04 – 12/22/04). We believe it is possible to manage the use of those beds more efficiently through the wise provision of some additional clinical and case management resources. Currently we have a plan in place that relies upon workers providing per diem services when the milieu becomes stressful and non-therapeutic at Battelle House. Unfortunately this plan depends upon a workforce that is over worked and under supported. Through additional reliable and consistent resources we believe it is possible to improve the efficacy and efficiency of diversion services accessible to the southern region of the state, thus reducing reliance upon psychiatric inpatient beds.

We are able to monitor usage of crisis intervention and crisis stabilization services through a daily "disposition meeting" at Battelle House. This meeting helps us to monitor the services, but is short of the goal of providing important face-to-face time with the psychiatrist to improve the outcomes of crisis stabilization.

The CRES Division also provides direct medical services for CRT consumers with chronic medical conditions such as diabetes. We have employed a part-time "care partner nurse" who monitors vital health care indicators such as Hg-A-1c levels, blood pressure, lipids and triglycerides, etc. as well as providing education, support and hands-on health improvement skills. We have found that this service is essential to plan and prepare for alternatives to psychiatric hospitalizations.

## Sub acute, longer term psychiatric rehabilitation services

UCS provides a residential program at the South Street Group Home. Currently the group home provides three congregate level beds downstairs, and a three-bed supported apartment program upstairs. Residents typically stay at the group home for one or more years. Staffing at the group home is provided by single-coverage 24 hours per day, 365 days per year.

We believe that is possible to improve the efficacy and efficiency of residential services through the provision of more person-tailored psychiatric rehabilitation and recovery services both for the residents of the group home and those persons transitioning out of the group home. These rehabilitation services may be provided in the same manner as the additional services needed at Battelle House, and they may potentially divert people from usage of group home services toward services provided in the community and in the home.

Additionally, we currently provide a small warm line service operated by residential staff. This service is being transformed into a consumer-operated warm line. Participants in the planning and implementation of the consumer-operated warm line also provide peer support groups in our CRT program. The coordination and support of these vital peer support programs is currently being improved and developed. These programs are currently blended into the professionally-staffed services provided by the CRT program, and improvement of this blending of services can only be accomplished through dedicated time and partnership. With the burden on the current workforce, this is difficult to accomplish and therefore the aforementioned additional staffing resources are essential to succeed in this endeavor.

## Coordination of service availability

We have spoken with the Executive Director of HCRS, and we are aware of a growing interest among providers in the southern region of the state to coordinate services and provide an efficient seamless network of care. Our willingness to work with this group is essential to assure success in the provision of both diversion services and sub acute psychiatric rehabilitation

services. We envision a more responsive back door to services needed beyond the scope of our array as well as a more welcoming and available front door to our own system of care through a coordinated southern network. Such a coordinated and reliable system of care is essential to take on the future needs of a statewide system oriented toward a decentralized inpatient network and a more responsive local system of care.

# SUMMARY OF UCS CAPACITY FOR EXPANDED LOCAL CONTINUUM OF SERVICES

1. **Crisis Stabilization/hospital diversion services**
    a. Serve as a regional resource for diversion
        i. Provide diversion beds at Battelle House – up to 30 days
        ii. Provide daily rehabilitation program
        iii. Resources needed:
            1. face-to-face access to MD or PA on a daily basis
            2. Care Partner Nurse
            3. diversion team including additional clinical services and case management services as well as blended peer support services

2. **Sub-acute, longer term psychiatric rehabilitation services**
    a. Serve as regional resource for step-down from diversion services
        i. Provide rehabilitation beds at South Street Group Home for up to 6 months
        ii. Provide intensive in-home rehabilitation for community living skill and resource development (some of the services that would have been provided through longer residence in the group home)
        iii. Resources needed:
            1. Ongoing therapy on an intensive level (2 or more sessions weekly)
            2. Case management support on an intensive level (3 to 5 visits weekly) to develop skills and resources needed for both intensive therapy and community living
            3. Coordination of medical health care through additional hours of the part time "care partner nurse"
3. **COMBINED SERVICES**
    a. Both of the services outlined above could be coordinated by an intensive unit of the CRT Program – combined resources would include additional hours of clinician availability and additional case managers working in consort with Battelle House, South Street Group Home and peer support programming.

December 30, 2004

Susan Wehry, M.D.
Deputy Commissioner of Health for Mental Health Services
Vermont Department of Health
108 Cherry St.
P.O. Box 70
Burlington, VT 05402-0070

Dear Dr. Wehry,
In my role as CRT Director here at WCMHS and on behalf of my colleagues at the Clara Martin Center and Northeast Kingdom Human Services I am writing to provide you a response to the RFI regarding the replacement for VSH. The three agencies have decided at the Executive and Senior Management levels to offer a collaborative response outlined in the enclose paper. This effort was one that came together very rapidly in the midst of the holiday season. Thus, while we have endeavored to provide the best answers to the Futures Committee and VDH concerns, we were not able to be as complete in all areas as we might have wished.

The agencies will refer to a shared title of Northeast/Central Collaborative or NCC in the response, however, we do not see our collaboration as static—i.e. we welcome participation from other D.A's and other entities who might be interested in the work ahead. In terms of contacting NCC regarding this proposal you may contact me at the number above, Cathy Rousse at NKHS, or Jeff Rothenberg at Clara Martin.

On behalf of NCC I thank you in advance for consideration of our proposal in the VSH replacement developmental process.

Sincerely,

Michael Hartman,
CRT/ICS Director

A Response
To the
Vermont Department of Health/Division of Mental Health
Request for Information Regarding Possible Partnerships in a Transformed Mental Health System

Submitted by
The Northeast/Central Collaborative:
The Clara Martin Center
Northeast Kingdom Human Services
Washington County Mental Health Services, Inc

Contact Persons:
Jeff Rothenberg, CMC
Catherine Rousse, NKHS
Michael Hartman, WCMHS

The "Request for Information Regarding Possible Partnerships in a Transformed Mental Health System" has led to a variety of discussions and meetings regarding how best to respond to it. These in turn have led to the formation of a tri-agency proposal by the Clara Martin Center (CMC), Northeast Kingdom Human Services (NKHS), and Washington County Mental Health Services (WCMHS). The proposal by what is now considered to be the Northeast/Central Collaborative (NCC) which follows outlines our combined vision of what services and facilities we believe can be provided by us, and other possible care partners, to meet the needs of the RFI put out by the Department of Health on December 16th, 2004.

Two agencies, CMC and WCMHS, have worked in tandem over the last 30 years to best serve mental health consumers in the Central Vermont area. These efforts most recently have included the contracted agreement between CMC and WCMHS to share resources to provide crisis services in the most economical model possible. Another example can be found in the creation of the Central Vermont Substance Abuse Services program that began through a joined effort by CMC, WCMHS, and the Howard Center. NKHS has not formally collaborated with either of the other agencies to provide ongoing services, but we have shared consumers across our catchment area boundaries. Also, the WCMHS and CMC CRT and Emergency programs have had positive referral and service experiences with the NKHS programs. As well, the former Developmental Services program director at NKHS, known as a strong collaborator with other agencies to provide quality services, has now become the Executive Director of the agency. Each of the agencies brings experience of collaboration with consumers, residential care, crisis intervention and diversion that compliment and strengthen the group as a whole. Thus we believe these working relationships can be extended to include some or all of the services needed as Vermont State Hospital transforms its role in the next 3-5 years.

While we have more experiences with some of the components than others we are interested parties in all of the service components. This includes being part of the solution to fulfilling the current state hospital's role of bottom line responsibility for care. We agree with all of the goals listed in the RFI, and believe we have a documented track record of meeting the goals listed:

- To fully integrate the functions of VSH into local health care (including local hospitals as they collaborate with NCC and DMH) and community mental health (designated agency) systems.
- To further the commitment to the principle of maintaining the locus of care in the community.
- To ensure that provided services are recovery oriented and trauma informed.
- To reduce the use of and need for involuntary care of all types, including inpatient.
- To ensure that all people with psychiatric disabilities, including those who are incarcerated, shall have access to high quality, clinically appropriate care across a broad continuum of services

While there is a need in all five of the counties represented by NCC for certain types of these service components we are interested in partnering not just in projects in our designated catchment area's but also especially those catchment area's that are adjacent to us. We believe that rather than create larger units, our area of Vermont would be better served in transforming the system by developing smaller units strategically and geographically positioned in the state

and working in collaboration to use all the area resources in the most efficient manner. This NCC proposal provides such a balance of regional collaboration while retaining local control.

The proposal as written seeks to address the following objectives:

- Serve persons who presently are inpatient in the Brooks Rehabilitation Unit of VSH.
- Provide services to divert proposed patients from hospitalization.
- Provide services to rapidly return persons who have been involuntarily hospitalized back to their local community.
- Provide services aimed at strengthening the recovery services for those who have been hospitalized via community supports to foster greater resiliency and ability to cope with crises.

**Blended Peer Support Programs**:
Both CMC and WCMHS have strong working relationships with Vermont Psychiatric Survivors and a record of peer provided services. WCMH has had a long standing consumer "warm line" and was one of the first agencies to have consumers working as peer support workers. CMC has partnered with Vermont Psychiatric Survivors (VPS) and NAMI - VT in the Safe Haven Program in Randolph, which is still the only such partnership in the country. Both these agencies had staff and consumers attend the recent trainings done by Mary Ellen Copeland on consumers working with individuals on Orders of Non-Hospitalization (ONH's). NKHS has not had an experience in peer supported services to the degree of the other two agencies, but has begun to move in this direction and is exploring how to best do so.

Any service component that we partnered with whether it be sub acute rehabilitation services, crisis stabilization services, inpatient care, and/or secure residential care would be encouraged to hire former or present consumers. The agencies would also be willing to explore the possibility of overseeing or consulting with other DA's or other entities that might be interested in the creation of new Safe Haven like programs, or the enhancement of programs that could serve a similar population. Our interest in this area is to support the development of programming that has been successful in our area.

Among the services currently provided by peer staff at either agency include:

- Staffing and support at the Safe Haven
- The Peer Line—a warm line available to WCMHS consumers daily from 6 – 11 p.m.
- Three 13 week recovery education series annually based on the Copeland model. This series is open to staff, any WCMHS consumers, and the general community as well.
- 1:1 tutoring on Recovery Education and individual WRAP development.
- Support and meals at a weekly soup kitchen in downtown Montpelier.
- Support for residential care at the Hillside Homes on Northfield St. in Montpelier.
- In home supports for grocery shopping, exercise, and general needs.
- Transportation and support for medical appointments
- Medication delivery and support.

WCMHS is following the lead of CMC in creating a working relationship with VPS that will see VPS peer's staffing WCMHS programs, the first of which is to be the Sunrise Recovery Center. Staff at Sunrise will be linked to those working at Safe Haven via VPS and will strengthen the supervisory capacity of VPS to support the staff working in Central Vermont. WCMHS expects to formalize the agreement with VPS regarding peer staff in early 2005. As mentioned previously NKHS is also pursuing the engagement of peers to provide key services as well.

**Acute Triage, Inpatient Diversion and Crisis Stabilization**:
WCMHS has been a leader in the Crisis Stabilization arena and reported to the VSH Futures Committee on the strengths of its current programs serving the VSH population and those who are diverted from it. In both Home Intervention (HI) and Chrysalis House programs WCMH is currently working with highly volatile consumers. At HI these persons are trying to remain in the community and avoid VSH or other involuntary care. At Chrysalis House we are transitioning persons with extensive histories of inpatient VSH care due to violent or destructive behavior. The Safe Haven program mentioned earlier also has a proven track record of transitioning individuals from different parts of the state from VSH. While NKHS has not operated a licensed mental health care facility, it has done so for the DS population for a number of years. As well the agency had some of the first community crisis diversion homes in the state using Short-Term Beds or STB's to do short term crisis assistance and diversion for consumers. NKHS also has been formulating plans for the creation of some facility based services for the last year and has been in discussions with the Northern Vermont Regional Hospital (NVRH) to create some more developed residential crisis options.

All programs referred to above have accepted admissions from other areas of the state, and would continue to accept such. We would see in the current planning, however, an opportunity to assist in either establishing such services in other areas and/or enhancing our current services to increase the acuity they might serve. We would advocate for the building of more of this type of beds either tied to a sub acute rehabilitation unit or as stand alone components.

At this time we could foresee at least two possibilities in this area. First that CMC has begun to explore the use of a site with access to a healthcare provider that would accommodate a Specialized Rehabilitation Unit and/or a crisis stabilization program. This could allow for ongoing and crisis level care in an area triangulated between Barre, White River Junction, and St. Johnsbury.

A second proposal is also related to a new Specialized Rehabilitation Unit, that WCMHS would relocate HI to be a joined location with this new service, probably in the Berlin area. The level of care at both facilities could be enhanced by co-location allowing for more efficient use of medical staff—Psychiatry, Nursing, and general medical needs. This would increase the ability of HI to accept persons who might require some nursing oversight on a 24-hour basis, and support the same for the Spec Rehab Unit. In both facilities under current VT Nursing Board regulations, the administration of medication and the writing of newly prescribed medication, including PRN's must be overseen by an RN. Co-location of these facilities would allow for this level of care and reduce the cost for it by sharing between the two facilities. We have had initial

conversations with local medical providers and a possibility of locating a general practice at this site as well would provide overarching medical care to persons at HI or in the Specialized Rehabilitation facility. This is a complicated scenario, but it does appear worth further exploration.

As mentioned previously, NKHS has engaged in discussions with NVRH to explore the use of the former Founders Hall space at the hospital as a crisis diversion or residential space. The current space could easily accommodate up to 6 persons and would be located within NVRH, thus having immediate access to medical care as needed. Any of these kinds of facilities could be run by individual agencies or NCC as a whole and/or with other partners, including the state if there was interest in doing so.

In terms of capacity it is clear that enhancing and relocating HI would increase the acuity that could be managed there and perhaps the number of beds by one or two. Chrysalis House currently has two residents in it, but within the two to three years for the VSH replacement to take shape, it is likely that two more residents could come into that program. The creation of beds in the St. Johnsbury region would be at least 6, but it is likely that more could be accommodated to also include the ability to manage persons with co-occurring disorders who might need to be in close proximity to a medical facility. Thus the number of diversion/stabilization beds could increase by 6-10 beds minimally.

NCC would also be interested in the: "Centralized care management capacity to manage the flow of clients among acute care programs, including entry into the system and disposition to appropriate levels of care." This would obviously involve working with the state and all of the other partners in the transformed system. We are especially glad to see this specifically mentioned in the RFI, as a concern for "managing the flow" of people through the system is strongly shared by all agencies. All the agencies are very familiar with Vermont law regarding patient's rights and involuntary care and would want to see clear rules, policies, and protocols for such a system and adequate legal protections for consumers at all parts of the system.

An especially important part of this management should involve the non-CRT enrolled involuntary patient. We would be very interested in pursuing the linking of immediate, but brief, therapeutic, case management services to these consumers. All the agencies have worked stridently for a number of years to reduce their use of VSH and to move persons hospitalized out of VSH as quickly as it is advisable to do so. We believe the creation of such a case management service to non-CRT consumers who are from our catchment area's and are hospitalized elsewhere and possibly non-CRT admissions to the CVMC Psychiatric Unit could reduce the Length of Stay (LOS) for these persons. This would be accomplished via diversion from a possible step up to a higher level of care—i.e. VSH or its replacement—and/or decrease the LOS of those persons thus creating more capacity at the DH's and VSH or its replacement.

The model for this brief, therapeutic case management is based in the ACCESS program at Washington County Mental Health, based in their Emergency Services Division. For nearly a decade this program has provided this type of service for children and adolescents, winning high praise from both inside and outside of the Agency. The Collaborative would propose the use of a

similar model for the area we serve, and would be willing to expand beyond those boundaries as might be desired or seen appropriate by DMH.

In terms of operation such a model could be run in tandem with those services currently performed by the DMH Care Managers, or a new system could be created, but a private/public model would likely have the greatest ability to manage cost and capacity. Regardless of the mix of funding or staff, NCC will exhibit an ability to triage, place consumers at optimal care levels, and then move them into or out of intensive care environments as such a diverse system of care will likely be more in need of such management than ever before.

The transportation of consumers across the newly created system of care is one complicated by what legal authority is bestowed upon providers. At present the movement of involuntary patients has been via law enforcement, ambulance, or once admitted, by VSH staff. It is clear that one aspect of concern expressed regarding transportation is how to make the process one that is not inclusive of anymore restrictive management than is necessary—e.g. handcuffs, or mechanical restraint—and is least trauma inducing. NCC supports the safest and most humane transport methods; however, we have had little time to develop a clear proposal. Thus, we can only offer a clear commitment to honor these areas of concern.

**Involuntary, Inpatient Care**:
The Acute Care model requires the commitment of a general hospital to be a partner in accordance with the Futures Committee statement of co-located care. At present we have not had formal discussions with any hospitals in our regions regarding this, though we are involved collectively in different projects with Central Vermont Hospital, Gifford Hospital, NVRH, Dartmouth Hitchcock Alliance and the VA Hospital. We are willing to be a partner in such a venture; however, this will require more time than is available to do so for this RFI. As well, we do also support a partnership with other DA's to create such a unit for the Central or Northeastern areas of the state, however, again more time would be needed to have a sense of how that could develop. One question we would propose to the Committee is whether the availability of health care through an existing FQHC or other community-based provider could be considered. We are a bit confused regarding some level of dissonance between the support for more community based mental health care, but a stipulation that it is provided within the context of an institutional based system.

The need for forensic evaluation was discussed extensively during the VSH Futures Committee meetings. NCC has not had adequate time to develop a strong proposal in this area and concerns about public safety and perception of such permeate this aspect of the VSH replacement. We are continuing to work to develop concepts, however, it is likely this would require significantly new skills and partners for NCC and its components, thus more extensive preparation is needed.

It has been discussed that there is a need to have persons in need of forensic evaluations placed elsewhere than VSH or its replacement. Given the information supplied by DMH that a portion of these referrals are seen as competent and therefore in need of treatment, we agree that hospitalization may not be the most appropriate level of care. We are willing to work in partnership with DMH to determine how to assist in this area, though the question remains as to how to best accomplish this.

As mentioned previously NCC is willing to work in tandem with any sites to best manage capacity issues for these units. This would hold true even if the units were not in our region, and our efforts would include creation and establishment of relationships with local courts regarding best service for involuntary forensic patients, while maintaining a system that can absorb all new referrals concurrently.

**Sub Acute Rehabilitation Care**:
As mentioned previously NCC has a clear interest in the operation of a psychiatric rehabilitation unit as described in the RFI, in partnership with the state and possibly local hospitals and/or other Designated Agencies (DA's). Our preference is to support the concept of expanding localized treatment access, thus we would propose the operation of up to two, 8 –10 bed units for long term rehabilitation patients from the acute care units established in replacement of VSH. We would be especially interested in partnering around one of these units for the North / Central part of the state. We are exploring the possibilities mentioned above as one of the sites for an 8-10 bed unit. All of these sites would be quite accessible to persons in the Central and Northeastern parts of the state, and for most of the remaining areas except for the most northwestern and southwestern areas.

The sites would incorporate access to medical care as needed either through local health providers, or through a general hospital. In all sites the agencies have historically good working relationships with health providers and would be able to construct healthcare arrangements as the project develops.

We do support the concept of these units as non-hospital alternatives, but do believe that certain standards of care as defined by the Licensing Division of DAIL for either a Level III care home or a Therapeutic Community Residence (TCR) should be employed. This unit would serve as a program operated in concert with the VSH replacement hospitals and be solely used for that purpose—i.e. direct referrals from the community or non-VSH replacement hospitals would not be accepted.

Regarding the Specialized Rehabilitation Unit in either location discussed above the number of beds would be 8-10, though both units could be utilized for up to 20 beds overall.

**Secure Residential Care**:
Regarding the residential forensic program for persons deemed in need of care, but no longer require a hospital level of such we again have not had time to reach a sense of clarity. Currently WMCHS has admitted into CRT two persons from VSH who had such histories, and CMC is currently doing so with another consumer who while not technically on a forensic status, presents with many of the same issues NKHS has also taken forensic VSH patients into the community and provided secure care. NKHS has also had long running residential services for sexual offenders that have a substantial positive record.

Many of the current models serving forensic and at risk offenders in Vermont utilize a model of wraparound for one or two offenders with significant staffing. NCC would support consideration of this model, and within our current experience believe we could provide this type of service.

Though we have willingness to address how best to serve all the stable VSH forensic population a concrete response was not possible within the tight frame of the RFI. It seems likely that an attempt to create a TCR like residence for this population could face significant challenges from communities. We philosophically believe strongly though in individual placements in the community as being in line with the systems values and beliefs about individualized care, close to home communities, reducing stigma etc. However this sort of initiative is going to need to be more clearly thought out with strong support from the state on whatever model is chosen for this component. Thus, we would want to have greater clarity on planning for this type of programming.

**Administrative and Clinical Considerations**

As stated in the November 30, 2004 Memo to the VSH Futures Committee from the CRT Directors the NCC supports the concept of private/public partnerships regarding replacement of VSH. This would entail a defined relationship with DMH, the DA's involved with this project, and any general or designated hospitals who wish to be a part of the system of care. This also includes setting clear benchmarks for outcomes and how failure to meet them would be addressed, but also included is the financial commitment that a plan followed is a plan funded. Unlike the often quoted history of ever decreasing state support following the closure of the Brandon Training School we expect that the state will honor the need to adequately fund this and other proposals to replace VSH. To foster such commitment the collaborating DA's seek a clear partnership with DMH that entwines all parties in the financial and management risks of a new model of care.

In the clinical realm we also support those concerns stated in the Memo regarding best care in a new model. These include:

- Significant flexible structure of care—especially at the crisis level—that allows for maximum consumer choice versus strict recipe programming
- Recovery education and principles need to be incorporated at all levels of treatment.
- Significant clarity should be established on what standards consumer/patient choice, participation, and collaboration are to be judged. We strongly support a model of maximization of consumer/patient collaboration that would encourage a realization of choice for what direction treatment can take.
- Families and other support persons from a patient's life must be creatively and openly encouraged to participate in the inpatient treatment.
- Co-occurring disorders and trauma informed care are also seen as major clinical components. All programs and all staff in those programs should exhibit their treatment approach concerning these areas and how they will maintain those components and train staff to them.

A significant concern of the NCC is how to manage issues of liability and the real cost of providing some of the proposed services in a new, community based setting. We are assuming that DMH/VDH will be willing to explore how best to partner on this issue to help facilitate community based care.

**Resources**

NCC recognizes that a number of resource issues will be faced in attempting to reduce the institutional based services of VSH. Some of these issues are very concrete—e.g. the creation of psychiatric time to oversee the care at a new HI or Specialized Rehabilitation facility. Other issues are somewhat less tangible, but no less needed--e.g. zoning exemptions that would allow for a secure facility in a town if it had 6 beds or less. This type of assistance has been provided in the past, especially in the case of the closure of the Brandon Training School, and greatly assisted in the establishment of community based resources. (Please refer to V.S.A.; T. 24; Ch117 (d) for further information regarding this specific example.)

Another very highly needed resource for this effort will be Information Technology (IT) services. The need for efficient communications of operational capacities and information sharing will be a key to the success of community based care. The moving of care from one central facility to a variety of sites across Vermont will require extensive IT resources to work effectively. Our respective agencies will continue moving toward improvement of our IT resources, but it will be extremely helpful if DMH can identify what targets might be helpful regarding this area so that NCC and other partners can try to move toward those as well.

**Civil Rights**

The NCC shares concerns that have been expressed by some members of the Futures Committee regarding access to legal services and protections. Given that consumers, once admitted as involuntary patients, lose a number of civil rights NCC strongly supports any effort to improve access to counsel and advocacy.

**Funding**

The NCC is concerned that any model ultimately chosen by the Futures Committee, and subsequently invested in by the state be one with adequate funding guaranteed. Though the entire system will no doubt be challenged by funding issues in the years ahead, persons who are involuntarily held should be guaranteed adequate and safe treatment. To suspend the civil rights of the patient is potentially a life-altering event for them. This effort must be allowed to occur without cutting corners thus compromising safety or respect in favor or saving dollars.

The NCC agrees and supports the statements made repeatedly by AHS Secretary Smith and Deputy Commissioner Wehry that start up and other funding to establish this new system of care will be granted through new funding, not be carved out of existing service budgets. This effort must be supported through the extension of funds to allow for community services to begin while existing hospital services still remain in place.

**Community Safety**

The NCC actively supports all efforts to educate the general populace on the mental health needs of its members and with the need for the safety of the public, as well as patients and staff. Concurrently we recognize that communities must cope with the acceptance of persons who are involuntarily treated within their own neighborhoods and a venue need be established that supports such a dialogue.

**Current VSH Employees**

The NCC shares concern about the employment of the skillful workforce that is now in place at VSH. VSH staff has helped a great number of Vermonters at their greatest moment of need. They have risked insult and assault upon their person to do a job that is complicated by knowing that when patients are the most symptomatic they will be challenging. Given the level of effort by the employees the Collaborative supports all efforts to ensure that a model that reduces employment and/or location of worksite has to also fairly address how these employees will be given an opportunity to continue their work, or transfer to work in such a way that respects their commitment to the citizens of Vermont.

December 31, 2004

Susan Wehry, MD
Deputy Commissioner for Mental health Services
Vermont Department of Health
108 Cherry Street
PO Box 70
Burlington, VT 05402-0070

Dear Dr. Wehry:

The Howard Center for Human Services (HCHS) was pleased to receive the "*Request for Information Regarding Possible Partnerships in a Transformed Mental Health System*" dated December 16, 2004. At a time when the economic, clinical, and contextual framework for providing and funding services to adults with serious and persistent mental illness is undergoing significant internal and external need for review and reform, this methodology for engaging and seeking input from multiple stakeholders in advance of and in preparation for the upcoming legislative dialogue is appreciated. As I am sure you can imagine, however, the timing to generate a meaningful and coordinated response during the last two weeks in December is challenged by the absence of so many during the holiday season. That limitation noted, and to the extent that we have been able to reach out and discuss among staff, managers and local stakeholders the issues raised by the RFI , we would like to offer the following comments for your consideration.

At the outset I would state emphatically The Howard Center's sincere and significant interest in entering into substantive discussions about an expanded role in Chittenden County in operating and/or partnering to operate an enhanced continuum of recovery-oriented, trauma informed, community-based services across the spectrum that would permit the replacement of the Vermont State Hospital (VSH) as it is currently configured. That said, and not unlike the letter you received on 16 December, 2004 from Dr. Robert Pierattini, MD, Clinical Leader and Chair FAHC Psychiatry Service on behalf of Fletcher Allen HealthCare our interest and ability will be more or less, dependent on the Division of Mental Health's (DMH) final position with regard to a number of structural, legal and economic parameters.

- How does DMH currently envision the management of economic and clinical risk in each or all of the proposed programmatic components? The recent crisis at VSH during this past year was noteworthy for, among other reasons, the State of Vermont's rapid infusion of dollars to increase staff salaries, address operational deficiencies, and substantially expand staff resources to address the noted deficiencies and needs. Though expecting proposed and planned community-based alternatives to the current VSH configuration to be well considered and avoid such pitfalls, what role would DMH and The State envision were such challenges to emerge in the provision of services by a community-based provider? Without wishing to dredge up failures of the past unnecessarily, when the State closed Brandon, community-based providers were then encouraged to offer more humane, clinically sound, economically advantageous solutions to move residents out into the community in exchange for which the state assured continued and sufficient

funding. As I am sure you know, the fiscal challenges facing Developmental Disabilities service providers in the upcoming funding cycle appear to be anything but consistent with that promise.

- Any proposed statewide community-based system will require an inordinately high degree of coordination between providers, the recovery community, local government and community and, here in Chittenden County, Fletcher Allen HealthCare. While we have not yet had detailed conversations with FAHC we have broached the idea and could envision the development of a model in which shared (for example, between HCHS, FAHC and Vermont State Employees) medical, case management, and nursing resources were structured in such a manner as to support client/patient movement through levels of care (e.g. inpatient, sub acute, crisis stabilization, residential) with consistency of built-in peer supports and a minimum of "new" staff handoffs. The HCHS and FAHC currently collaborate and share staff/resources in several high profile clinical services (e.g. Mobile Crisis, The Methadone Clinic, Act-I/Bridge) which could serve as a template for expansion into enhanced continuum of care modeling here in Chittenden County.

- Minimum VSH hospital-based bed capacity must be maintained at no less than the current levels. Though step-down and sub-acute services expansion as well as enhanced peer services models, over time, may demonstrate an ability to reduce such capacity, it would be premature in the planning stage to construct a service model on an unproven assumption. That said, on Page 3 of the RFI the necessity for 8 Department of Corrections (DOC) beds is highlighted. Since these beds are not now part of the 54 VSH beds, is DMH proposing consideration of a model that would establish 62 beds system wide? Or is DMH expecting that the developed system will have 8 less beds than current capacity to accommodate a population shift to satisfy the current unmet need of DOC? Clarification here of DMH's position is critical.

- A shift from a centralized state-operated facility with a "no-denial" policy to community-based beds with a similar expectation will necessitate a needed review of the philosophy of service offered throughout the state. Our experiences as a provider of crisis assessment and referral as well as post inpatient case management would suggest that significant change will be necessary in order to actualize an efficient system that is not confronted with patients in need of voluntary or involuntary admission and bed-based providers unwilling to accept them.

- On Page 4, the seventh bullet, the RFI highlights the broad range of clients expected to be served by the "transformed system." This listing appears to represent a significant expansion (with regard to TBI, DD and, to some extent, trauma) of populations currently served at VSH. The issue/challenge/opportunity to serve these populations is not, be definition, the problem. Rather, such expansion appears to highlight the need for clarity with regard to the resource allocation and distribution methodology given the current practice that links diagnosis with how clients are served and funded. As you know, adults with SPMI are funded through the Medicaid Waiver Case rate system, while clients in the DD populations are served on an individual waiver basis. Will the change in modeling capacity necessitate changes in either or both waiver models? Will funding for all

clients/patients be consistent across diagnostic categories? And, perhaps at the root of these questions, Is it the state's intent to conform the developed model to the existing waivers or to develop a desired model and then seek the (if) necessary amendments to the waivers?

- Chittenden County is the only real urban center in the state. It is likely that dispersal of the VSH caseload (as a result of acute admissions and subsequent case management, medical oversight and housing needs) will disproportionately have a greater impact on the greater Burlington area. Earlier reductions of VSH census demonstrated this trend in Washington County. Similarly, "*A Study of Detention in Vermont*," December 30, 2003 by The Department of Corrections noted that (based on 2001 population estimates) Chittenden County had 24.3% of the state's population but 34.9% of detention days. Any change in the location of VSH beds will no doubt exacerbate an already critical problem in housing in the Burlington area. Supervised apartments, shared-living arrangements, group homes, transitional housing and community-care homes are all inadequate to meet the current need and contribute, in no small part, to the "back-up" in the movement of clients throughout the system. Any transformed system must address this end of the service spectrum with the same vigor as acute bed access.

The Howard Center, a part of the not-for-profit designated community mental health system, has demonstrated a level of clinical and programmatic excellence, as well as fiscal accountability, in the development and delivery of services across the community-based spectrum: Programs such as the Next Door Program (Sub-acute/), Assist (Inpatient Diversion), Westview (peer-mediated vocational services), Lakeview (Community Care), 72 (Supervised living), Arroway (Group Homes), and CODTP (co-occurring treatment program), as well as taking the lead in integrating recovery, substance abuse and trauma informed services across Case management and facility-based programming. We believe that the current plan to reorganize where and how services are delivered offers an opportunity to enhance what and how we meet the needs of consumers and our community by further developing clinical and economic impacts for:

- Expanding the Assist program from 4 to 10 beds
- Replicate the Next Door Program as a non-transitional alternative
- Expand Lakeview Community-Care Home capacity
- Add additional peer-mediated supervised living alternatives
- Expand vocational integration to maximize community re-entry
- Integrate staffing with FAHC inpatient services
- Greater integration of trauma, substance abuse, & recovery modeling

We expect that after consideration by you and your staff, the VSH Futures Committee, The Secretary of The Agency of Human Services, and the Mental Health Oversight Committee of the legislature a Request for proposals (RFP) will emerge that will accurately reflect what is envisioned to be needed and what must be sufficiently funded. And, that the existing designated hospitals and designated community mental health centers across the state, as not-for profits with a demonstrated and successful history acting on behalf of the state, will preserve, expand and establish viable models of cooperation and integration that takes full advantage of the strengths

of their respective systems in the interests of enhanced services to consumers, their families, and our communities.

Sincerely,

Robert W. Bick,
Director, Adult Behavioral Health Services

January 3, 2005

Susan Wehry, MD
Deputy Commissioner of Health for Mental Health Services
Vermont Department of Health
108 Cherry Street
P.O. Box 70
Burlington, VT 05402-0070

Dear Dr. Wehry,

Attached please find Springfield Hospital's response to the Department's Request for Information dated December 16, 2004.

We are currently developing facility, program, and staffing plans which will be incorporated into a formal proposal pending receipt of the additional information requested through VAHHS on December 15, 2004. I am confident that both our proposed capital and operating costs will be very competitive.

Springfield Hospital looks forward to working with the Department and other interested parties in assembling the envisioned VSH replacement system.

Sincerely,

Glenn Cordner
Chief Executive Officer

GC/cs

Enclosures

**SPRINGFIELD HOSPITAL**

**RESPONSE TO**
**VERMONT DMH RFI**
**FOR**
**VSH REPLACEMENT SERVICES**

## Overview

The Springfield Hospital has a long-standing commitment to providing high quality psychiatric services to the most seriously mentally ill individuals in the state of Vermont. This has occurred directly through the following Springfield Hospital services:

**The Windham Center inpatient program**
**The Psychiatric Partial Hospitalization program**
**The Dialectical Behavioral Therapy intensive outpatient program**
**Buprenorphine Clinic services**
**Co-occurring Disorder capable services throughout the continuum**
**Springfield Hospital Emergency Room services**

In addition, Springfield Hospital has developed this commitment through collaboration with HCRS in the provision of psychiatric crisis services, and in the elaboration of a continuum of care involving hospital alternative services and CRT case management.

Further, Springfield Hospital has established itself as a partner with Vermont DMH in the development of designated acute care services in general hospitals, and was the first community hospital in the state to accept patients on involuntary 72 hour hold status. In addition, Springfield Hospital piloted consumer satisfaction surveys provided by Vermont Psychiatric Survivors, and was the first hospital to have all staff participate in Recovery Training by VPS.

In this context, Springfield Hospital continues to wish to play a significant role in partnership with Vermont DMH in developing an appropriate array of community based alternatives for individuals currently receiving services at the Vermont State Hospital.

This proposal includes a range of possible options, in response to the possible needs outlined in the RFI. They include: Expansion of acute intensive care and general acute inpatient capacity at the Windham Center; expansion of capacity in the Windham Center continuum of care (partial hospitalization and DBT); expansion of crisis diversion and med/psych capacity at the Springfield Hospital; collaboration with HCRS and others in the development of crisis step-down capacity and sober supported housing to support a continuum of care; and clinical and management consultation services to any community hospital without inpatient psychiatry experience that wishes to provide VSH replacement services.

**Acute Inpatient Expansion:**

The Springfield Hospital proposes to expand its existing Windham Center bed capacity to 24 beds, increasing average daily census by approximately 6 (the maximum that can be accomplished without risking IMD designation problems), and adding 5-7 of the existing beds to the mix, to dedicate 12 of the 24 beds to VSH replacement capacity.

These beds would be developed in the existing building in Bellows Falls, by expansion into available space on the same floor, with additional office space on the lower floor. This will significantly control capital costs in the expansion, since the building (the former Rockingham Memorial Hospital) functioned as inpatient space in the past. The floor plan would be designed to incorporate both an intensive care capacity and a "normal" acute care capacity in two wings with a substantial proportion of single rooms and a common nursing station, to allow for maximal flexibility in assigning patients. In addition, enhancements in staffing and provision of on-site security around the clock would permit accepting the full range of patients regardless of acuity, and would permit accepting patients who required Act 114 involuntary medication, as well as seclusion and restraint (which we have used very sparingly and will continue to make every effort to use minimally). Further, the building already has on site urgent care, and procedures for access to all necessary medical services; this will be expanded with on site physician or physician assistant capacity dedicated to the inpatient unit, as well as expanded capacity for access to laboratory and other testing under the aegis of the Springfield Hospital. Finally, the flexibility in space would permit not only work with the most severely acute patients but would allow for the capacity to work with patients who required a longer length of stay for hospital level rehabilitation (we already have experience with some severely ill patients who have required acute stay up to 70 days), particularly for those who might benefit from co-occurring substance abuse treatment and/or DBT.

In addition, the Springfield Hospital pledges to have at least one bed always available for surge capacity requirements, and will develop clearly articulated policies and protocols to ensure such availability at all times. Some of this capacity will be linked to additional capacities listed below.

**Continuum of Care Expansion**

In addition to the above, Springfield Hospital will expand capacity in its existing partial hospitalization, intensive outpatient program, adult outpatient services and DBT programs to provide a broader continuum of services to these additional patients with significant needs. Additions will also include incorporation of more extensive co-occurring substance abuse services in all levels of the continuum.

**Expanded Capacity at the Springfield Hospital location**

Springfield Hospital is evaluating expanding capacity as part of this project in two major areas. First, Springfield Hospital proposes to develop secure space within the hospital to provide 23-hour emergency holding bed capacity to facilitate hospital diversion and to permit more ability to manage surge capacity needs. Second, Springfield Hospital will explore developing 4-

bed secure med/psych capacity in the medical part of the hospital in order to accommodate any patients with both severe psychiatric and severe medical acuity. If this expanded capacity is used even at 50% occupancy, this will expand Springfield Hospital's medical census, and thereby permitting a higher psychiatric census at the Windham Center campus.

**Collaboration with HCRS to develop Hospital Alternatives**

Springfield Hospital will work in collaboration with HCRS to facilitate hospital diversion and movement of patients through the hospital continuum. This will involve, first, developing a collaborative plan to expand the capacity of residential programs to function as a hospital diversion program on referral from the 23 hour holding bed, or as a step down from the inpatient unit, to facilitate access for more acute patients. This will incorporate capacity to combine these residential needs with Partial Hospitalization and/or DBT, as well as to provide specialized co-occurring disorder treatment.

Second, Springfield Hospital will work with HCRS and others to develop community supported sober housing for individuals with significant psychiatric and substance use disorder co-morbidity who need a safe living environment combined with access to partial hospital or outpatient support for continued sobriety.

Third, Springfield Hospital will work to expand its existing collaboration with the HCRS crisis team to be able to manage acutely and severely mentally ill patients successfully throughout the continuum of care provided by the Windham Center and HCRS.

**Clinical and Management Consultation to other hospitals**

Recognizing that there may be hospitals with little experience in psychiatric acute care who may be interested in providing licensed beds to assist in the VSH Replacement effort, Springfield Hospital is willing to offer psychiatric clinical and management consultation to assist in the development of a successful program in those settings.

**Financial and Space Analysis**

As part of its commitment to the design of this proposal, Springfield Hospital has engaged Public Consulting Group of Boston, MA, to undertake an initial feasibility and design study of both the financial and space elements supporting the above proposals. This initial feasibility analysis has created a framework for how to expand census within the IMD constraints, and provided an initial outline for how to use available space to construct the model of service being proposed. Further and more detailed analyses will be conducted once more information is provided concerning the nature of the population and the expected surge capacity requirements.

August 27, 2004

Susan Wehry, MD
Deputy Commissioner for Mental Health
Department of Health
Division of Mental Health
103 South Main Street – Weeks Bldg.
Waterbury, VT 05671-1601

Dear Dr. Wehry,

I am pleased to respond to your letter of August 20, 2004. Springfield Hospital has a long history of successfully operating a community-based inpatient and outpatient psychiatry program which is highly regarded by patients, patient advocates, referring practitioners, payers, and regulators.

Of our 69-licensed beds, 20 are dedicated to our psychiatric program, The Windham Center for Psychiatric Care, which also includes a partial hospitalization program with an average census of about six and a DBT program with a current census of ten. We employ three psychiatrists on our active Medical Staff. We were one of the first community hospitals to be certified to provide 72-hour hold involuntary care and one of the first to be permitted to provide involuntary care beyond 72 hours. We also provide a contracted one half to one day per week psychiatrist service to inmates of the Southern Vermont Correctional Facility in Springfield.

We are proud of The Windham Center Program and very committed to its important work. Philosophically, as I am sure the Division staff will testify, our desire has always been to be a willing and cooperative partner in helping to do what is needed to be done and doing it well.

At this very important juncture in planning the future of psychiatric care in Vermont, we are again eager and willing to play an important role in both planning the system and being part of it. At this early stage, I would enthusiastically offer our resources and expertise in any way you wish to enlist us and we would be open to considering any role for which a community hospital is a desired partner.

As you know, operating under our own hospital license, we have limited capacity for more psychiatric inpatients (about six, I believe) before we would hit the IMD threshold. We could add those and reconfigure the total to provide more system value in the current environment, or we could provide contracted program management to a unit licensed under another provider.

In conclusion, we have an excellent history as a provider, we are a cooperative and willing planning partner, we are very interested in expanding our role as a provider, and we are flexible as to the model and design in which we might work. We look forward to working with you and your team.

Sincerely,

Glenn Cordner
Chief Executive Officer

GC/cs

cc: Bea Grause, Hospital Association
Dr. Paul Jarris, Commissioner, VDH
Beth Tanzman, Director Adult CMH Programs
Tom Simpatico, VSH Medical Director
Ken Minkoff, MD, Consulting Medical Director, Windham Center
Chris Lorbati, MD, Medical Director, Windham Center
Janet Harvie, RN, BSN, Director of Patient Care Services, Springfield Hospital
Jim Walsh, RN, Nurse Manager, Windham Center
Bev Snow, Program Director, Windham Center

December 13, 2004

Susan M. Wehry, M.D.
Deputy Commissioner for Mental Health
Vermont Agency Of Human Services
Office of the Secretary
103 South Main Street
Waterbury, VT 05671-0201

Dear Dr. Wehry:

This letter serves to confirm the Retreat's interest in hosting a 16-bed acute care unit with capacity for intensive care patients at the Brattleboro Retreat. The Retreat proposes creating a total of 16 beds divided as follows: Ten (10) beds for general psychiatric acute care patients and a six (6) beds for psychiatric intensive care unit. There will be capacity to flex between the two units, altering the ratio of acute care to intensive care beds, with a total capacity remaining at 16. The total number of FTEs needed to provide care to the units is 39.6 - non-physician FTEs and one physician FTE. The staffing is made up of nurses, mental health workers, social workers, activity therapists, a program manager and two unit clerks.

The physical facilities at the Retreat would need renovation in order to accommodate the configuration described above. Without a complete understanding of patient needs, it is difficult to provide a detailed cost estimate at this time.

This letter of interest is conditioned upon a more detailed understanding of the clinical needs of patients, the development of adequate step-down services and linkages between the levels of care as described by the VSH Futures Group.

I hope this is helpful to you in confirming the Retreat's interest in providing services to patients currently being served at Vermont State Hospital. I look forward to continuing to work with you to meet the needs of individuals with mental health and substance abuse problems in Vermont.

Sincerely,

Richard T. Palmisano
President and Chief Executive Officer
TP/ban

cc: Julie Peterson, Chair, Board of Trustees
Beatrice Grause, President/CEO V AHHS

# Fletcher Allen Health Care

16 December 2004

Susan Wehry, M.D., Deputy Commissioner of Health for Mental Health
Vermont Department of Health
108 Cherry Street
Burlington, Vermont 05401

Dear Susan:

Fletcher Allen Health Care expressed in an October 21 letter to the Mental Health Oversight Committee of the legislature an interest and willingness to enter a discussion about expanded inpatient psychiatry capacity in Burlington. The purpose of this letter is to reconfirm that interest and to provide a conceptual proposal as to how Fletcher Allen might become involved.

Before outlining our proposal, let me first express several caveats. First_ our proposal at this early stage merely defines the broad parameters for involvement by our organization, and a more detailed proposal obviously would require much further discussion and planning. Second, as we have discussed with you on previous occasions, Fletcher Allen is committed to ensuring full involvement by our neighbors, the advocates, and our community in matters relating to our psychiatric services. To that end, any planning that might develop will require the participation of Ward 1, the Mental Health Program Quality Committee, Howard Center for Human Services, and the City of Burlington, and any decision-making by Fletcher Allen will be subject to input from these and other important constituencies. Third, any decisions and actions taken by us as a result of this planning will ultimately require approval from our Board of Trustees.

With these caveats in mind, we are most interested in discussing further a proposal by which Fletcher Allen could become involved in the management and/or staffing of a state-owned inpatient psychiatry facility proximate to our Medical Center campus in Burlington, constructed and operated with state funding. As noted in our earlier letter, the size of the facility could be relatively flexible, depending on the statewide plan adopted by the Division of Mental Health and the legislature. However, because we do not have existing space or capacity for such a facility presently, new construction would be required with a commitment of state capital expenditures to cover the cost of this construction. Further, Fletcher Allen is not in a position to subsidize the costs of operating the facility and would need assurance of stable sources of funding during the period of our involvement in the facility.

We believe there are a number of factors that would favor the location of a new facility proximate to our existing hospital campus in Burlington. We currently operate approximately 28 psychiatry beds, but we are building two new inpatient units that are expected to be completed in the fall of 2005. At that time, we will have 28 beds, many of them single-occupancy, sixteen of them on the secure unit. These units are located near our emergency department and near

hospital medical/surgical beds, so admissions from the Emergency Department to psychiatry are easily accomplished, as are transfers from and to medical/surgical units. We have 24-hour in-house psychiatric coverage, excellent consultation resources from our colleagues, and we frequently manage complex psychiatric patients admitted to medical/surgical units for other care. The

overall system is well-organized and well-integrated. We are utilizing our full capacity now, and we expect that demand in our region will fill the additional beds as soon as they are built.

The public mental health system could capitalize on the existing capacity and programming by building a third (and potentially fourth, if that is desirable) 16-bed unit nearby, then coordinating its programs with services now available at Fletcher Allen. All or part of this additional unit could be built and staffed to manage patients who cannot be managed on the existing secure unit. With a third unit, the Shepardson 6 secure unit could serve special functions: an admission/evaluation unit, a unit for patients requiring medical care (beyond minor interventions), and a unit for frail or vulnerable people who require a secure unit. The new unit could be designed and staffed to manage longer-term patients and more aggressive patients. Both secure units could be quite flexible about a broad range of patients who could be served on either unit, but future planning would have to include discussion of patient populations who would be served in these facilities.

The northwest Vermont region needs sub-acute transitional capacity for patients who are admitted but no longer need an inpatient level of care, and a successful, cost-effective inpatient program will require this kind of programming. The sub-acute facility would continue treatment of patients who are not well enough to live independently with available housing options in the region. The sub-acute facility should develop expertise for caring for patients who refuse medication. This could include motivational and educational programming or programming designed to optimize functioning and well being without medication. Any future clinical programs in Chittenden County should be developed in conjunction with Howard Center for Human Services, but this is particularly true of sub-acute care.

If these new units are close to the MCHV campus, the inpatient psychiatrist could follow the patient to different levels of care, from emergency presentation to transitional sub-acute program, enhancing continuity of care. The creation of inpatient and sub-acute care also offers an opportunity to co-locate other neuroscience programs within a new complex. These might include partial hospital services, clinical neurology programs, neurophysiology, and research.

There are three factors that limit inpatient management of aggression now: the physical plant, patient mix, and staffing. The Shepardson unit, and future inpatient units, will address the architectural needs for inpatient hospitalization. To increase our ability to manage more aggressive patients, we have to be able to separate them from elderly and frail patients, and from patients who have a history of aggressive trauma. This separation will require a third unit, but any increase in capacity would require a third unit anyway.

We are currently staffed to manage moderately aggressive patients, with rare one-to-one staffing. We have typically relied on the Vermont State Hospital to manage patients who require intensive

supervision. We can adjust staffing to accommodate a different patient mix, with a resulting higher cost, provided that cost increases are addressed in a future affiliation agreement.

As we explore alternatives to the current Waterbury site, it is important to remember that all planning to date assumes the health and continued participation of our designated hospital system and community mental health agencies. The designated hospital system has functioned very well in our community-based system of care, and we must ensure that new programs do not harm any of the existing hospitals. The needed new capacity will be greater if any hospital reduces the number of psychiatry beds. The fortuitous geographic distribution of our hospitals permits local care and treatment coordination. Inpatient psychiatry units in general hospitals now function to provide immediate assessment and acute stabilization, a role that is defined by clinical considerations, third-party payment, and the cost to the community.

We hope that the proposal above complements and preserves the system of regional designated hospitals. If the program opportunities, academic affiliation, and Chittenden County location are of interest, we could proceed to analyze programs, staffing, and costs more precisely. At the appropriate time, we can also convene major stakeholders to elaborate these preliminary ideas.

Sincerely,

Robert Pierattini, M.D., Physician Leader and Chair
FAHC Psychiatry Service, UVM Department of Psychiatry

December 22, 2004

Dr. Susan Wehry
Deputy Commissioner, Mental Health 103 South Main Street
Weeks Building
Waterbury, VT 05671-1601

Dear Dr. Wehry:

**Response to request for information:**

Services for Patients Currently Hospitalized at VSH

Rutland Mental Health Services fully endorses Rutland Regional Medical Center's desire to pursue the development of a Psychiatric Intensive Care Unit and expand our mutual efforts in serving involuntary psychiatric admissions. We believe that an appropriate continuum of services must include psychiatric intensive care and inpatient care, subacute care and residential services. To that end, Rutland Mental Health Services and Rutland Regional Medical Center are collaboratively willing to explore the development of sub-acute and residential services in the greater Rutland area. Additionally, I have had the opportunity to speak with Judith Hayward of Health Care and Rehabilitation Services of Southeastern Vermont, and we will mutually explore strategies to develop a full continuum of services for Southern Vermont. This will involve discussions with Brattleboro Retreat, Springfield Hospital and United Counseling Services.

I wish to thank you for the opportunity to express our mutual interest in better serving the needs of Vermonters. Should you wish any further information, please feel free to contact me.

Sincerely,

Mark G. Monson
President and Chief Executive Officer

cc:

Judith Hayward
Tom Huebner

December 7, 2004

Dr. Susan Wehry
Deputy Commissioner, Mental Health 103 South Main Street

Weeks Building
Waterbury, VT 05671-1601

Dear Dr. Wehry:

Rutland Regional Medical Center (RRMC) wishes to express formal interest in pursuing the development of a Psychiatric Intensive Care Dnit (PICD), and to expand our efforts in serving involuntary psychiatric admissions. Our preliminary plan involves the development of an eight bed PICD, located adjacent to our current existing nineteen bed General Psychiatric Dnit. This would require extensive renovation and relocation of an existing nursing unit.

The PICD would serve patients with poor behavioral control suggesting a high risk of suicide, violence or property destruction. . Additionally, the PICD would be utilized for individuals who are unable to tolerate environmental stimulation of the General Psychiatric Dnit, and for individuals who have regressed into a confused or disoriented state with evidence of potential inadvertent danger to self and others. The PICD would have the potential flex from five beds to eight beds depending on the needs of the patient population.

In addition to developing a PICD, RRMC proposes to make available an additional nine existing acute psychiatric beds, which are currently under-utilized. A significant benefit of the addition of these nine beds is that little or no renovation would be required. Thus, psychiatric capacity at RRMC could be increased to 17 beds through the addition of the eight bed PICD, and maximizing existing underutilized capacity. A total of 27 psychiatric beds would be available to voluntary and/or involuntary patients throughout Vermont. Approximately, forty two new staff members would be hired in order to appropriately respond to the acuity of the target patient population.

We wish to thank you for the opportunity to express out interest in better serving the needs of Vermonters. Should you wish any further information, please feel free to contact us.

Sincerely,

Mark Monson
Vice President of Clinical Operations

Thomas W. Huebner
President & CEO

**E-mail received on January 3, 2005 from Stephen Broer, of Northwestern Counseling Service and Support.**

Susan,

My apologies for not sending you our agency's response to your Request for Information. I was away on vacation and returned today and did not have time to put together a formal response. I have been in contact with Nick Emlen from the Council and Ted Mable, our Executive Director. Nick informs me there will be other opportunities to share our thoughts and interest in supporting a more substantive community continuum of care for adults with severe and persistent mental illness.

In addition to our participating in the CRT Directors discussions that resulted in the 11/30/04 memo to the VSH Futures Committee and our support for the concept of a private/public partnership to replace VSH as we know it, we value our collaboration with neighboring Designated Agencies and Designated Hospitals. With regards to specific service components, our Standing Committee has been discussing a range of peer support options. We have also been exploring ways to increase our capacity to prevent hospitalization through our two residential programs (22 Upper Weldon & 174 North Main Street) as well as other alternatives. With additional support, each of our System of Care Local Priorities (2004-2007) can be modified to target hospital diversion, transition from hospitalization, and increase the overall quality of life for the consumers in Franklin and Grand Isle counties.

We look forward to participating in future discussions related to this important need area. I will be at the CRT Director's meeting on Friday to review outcomes from your meeting tomorrow.

Sincerely,

Steve Broer, Psy.D.
Director, Behavioral Health Services
Northwestern Counseling & Support Services
107 Fisher Pond Road
St. Albans, VT 05478
(802) 524-6555 x233

# Appendix B

## State of Vermont
## Department of Health
## Actuarial Study of the Needed Bed Capacity for Adult Mental Health Services

***Prepared by***

**Milliman, Inc.**

**June 2, 2006**

Click here to review the Actuarial Study

# Appendix C

## The Vermont Mental Health Futures Plan Proposal
## To Transform and Sustain a Comprehensive Continuum of Care
## For Adults with Mental Illness

## Presented to

## The Legislative Mental Health Oversight Committee
## March 22, 2006

## Approved by the Committee with Two Amendments
## Revised April 25, 2006

# THE VERMONT MENTAL HEALTH FUTURES PLAN

## Proposal to Transform and Sustain
## A Comprehensive Continuum of Care
## For Adults with Mental Illness

Presented to the
Legislative Mental Health Oversight Committee
March 22, 2006

The Agency of Human Services
Department of Health
Division of Mental Health

Approved by the Committee
With two amendments
Revised April 25, 2006

VERMONT

**Department of Health**
Division of Mental Health
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*Agency of Human Services*

March 22, 20006

Representative Anne Donahue
Representative Gail Faller
Representative Michael Fisher, Co-chair
Senator James Leddy, Co-chair
Representative Pat O'Donnell
Senator Philip Scott
Senator Diane Snelling
Sen. Jeanette White

Mental Health Oversight Committee
State House
Montpelier, Vermont

Dear Committee Members,

The Vermont Mental Health Futures Plan calls for the continued transformation of our service system towards a consumer-directed, trauma-informed, and recovery-oriented system of mental health care. The core of the plan is proposed new investments in the essential community capacities, along with reconfiguration of the existing 54-bed inpatient capacity at the Vermont State Hospital into a new array of inpatient, rehabilitation, and residential services for adults. This plan is consistent with Vermont's long history of establishing strong community support systems and reducing our reliance on institutional care. The fundamental goal is to support recovery for Vermonters with mental illnesses in the least restrictive and most integrated settings.

This plan is based upon recommendations from the Vermont State Hospital Futures Advisory Group and discussions with your committee. It is also informed by:

- The Designated Agency Sustainability Study,
- The Vermont State Hospital Futures Plan: Report to Charles Smith, Secretary AHS (the Division of Mental Health's report)
- Recommendations for the Future of Services Provided at Vermont State Hospital (Secretary Smith's Futures report to the Legislature)
- The Health Resources Allocation Plan (H-RAP)
- The State Health Plan.

The enclosed plan builds on the previous work, updates the implementation status of VSH Futures Plan components for which there have already been appropriations, and outlines the work to do in the coming months and years.

This document is intended to continue fulfilling the requirements set out in the Fiscal Year 2005 Appropriations Act (Sec. 141a.) for Vermont State Hospital Future Planning.57

Specifically, AHS Secretary Cindy LaWare is seeking your committee's approval for the overall scope and direction of this Futures Plan as presented, and your approval to proceed with the next phases of project implementation.

Respectfully submitted,

Cynthia D. LaWare, Secretary
Agency of Human Services

Beth H. Tanzman, Director
Mental Health Futures Project

[57] The secretary of human services shall be responsible for the development and, upon approval by the mental health oversight committee and joint fiscal committee, implementation of a comprehensive strategic plan for the delivery of services currently provided by the Vermont state hospital developed within the context of long-range planning for a comprehensive continuum of care for mental health services.
On or before January 15, 2005, the secretary shall prepare and present to the mental health oversight committee and the joint fiscal committee a report containing a comprehensive implementation plan for replacing the services currently provided by the Vermont state hospital developed within the context of long-range planning for a comprehensive continuum of care for mental health services. The report shall include proposals for legislation and capital and operational funding needed to implement the plan.

# THE VERMONT MENTAL HEALTH FUTURES PLAN

## Proposal to Transform and Sustain
## A Comprehensive Continuum of Care
## For Adults with Mental Illness

Revised April 25, 2006

## Contents



## List of Appendices

# Overview of the Transformed System
# THE **FUTURES** PLAN

The Vermont Mental Health Futures Plan calls for the transformation of our service system towards a consumer-directed, trauma-informed, and recovery-oriented system of mental health. When fully implemented, the plan will transform inpatient and recovery services for the most severely ill and will improve coordination of services and increase capacity for all adults with mental illnesses. The result will be a continuum of care in which

- The individual is actively engaged in their own recovery.
- Prevention, early intervention and alternatives to more acute levels of care are pursued aggressively.
- Peer supports are expanded and recognized as essential to recovery.
- All the elements are coordinated.

This plan is consistent with Vermont's long history of establishing strong community support systems and reducing our reliance on institutional care. The fundamental goal is to support recovery for Vermonters with mental illnesses in the least restrictive and most integrated settings.

The replacement of Vermont State Hospital (VSH) services is proposed to take place within the context of the system's transformation towards care that is more integrated with the rest of medical care, and that emphasizes reduced reliance on inpatient care.

The core of the plan is the proposal for new investments in the essential community capacities, along with reconfiguration of the existing 54-bed inpatient capacity at VSH into a new array of inpatient, rehabilitation, and residential services for adults.

### *New Inpatient Capacity for Intensive Care and Specialized Care*

Two new levels of inpatient care, "intensive care" and "specialized care," are proposed, reflecting more intensive staffing patterns than currently exist at VSH or in Designated Hospital psychiatric inpatient programs. These new levels of care each will be configured with high staff-to-patient ratios, flexibly scalable environments, and specialized clinical programming. The intensive care service is planned for stabilization of individuals with the most dangerous behaviors. The specialized care service will offer staff-intensive programming, and the longer lengths of stay required by individuals with particularly severe or unresponsive symptoms. The plan proposes to create 32 new inpatient beds comprised of 12 intensive care and 20 specialized care beds.

The new inpatient programs will be created in three locations.

- A new facility is proposed to be built located at or adjacent to a hospital, preferably a tertiary level, academic medical center (Fletcher Allen Health Care). This program will provide both new levels of inpatient care, intensive care and specialized care.
- Retreat Healthcare and Rutland Regional Medical Center have agreed to enhance their capacity to develop specialized care inpatient programs. This will assist geographic access specialized inpatient care and will provide the entire system with needed surge capacity.

### *New, Residential Recovery and Secure Residential Treatment Programs*

The plan proposes to create two new programs designed to meet the needs of a longer-term care population currently served at VSH but who do not need inpatient-level care. These programs are residential recovery programs for sub-acute rehabilitation, with a capacity of 18, and secure residential treatment, with a capacity of six.

The ***residential recovery programs*** are designed to meet the needs of individuals who have experienced repeated hospitalizations or extended stays at VSH. These individuals often have a slow response to treatment and multiple disabling conditions. With individually focused rehabilitation programming in non-institutional settings, this population is believed to be capable of making significant gains towards recovery. The current VSH environment, while very caring and supportive, is fundamentally institutional. As such, it constitutes a very difficult environment for engagement in the building of adequate recovery skills to successfully maintain recovery in a less-structured setting.

***Secure residential treatment programs*** will be designed to meet the needs of individuals whose symptoms are sufficiently stable to no longer need inpatient care, but who are legally restricted from discharge from a secure setting.

### *Crisis Beds for Stabilization and Diversion*

The plan proposes to augment the existing network of **crisis beds** for stabilization of an individual's crisis within a community setting and diversion from hospitalization. The goal is to develop programs to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization. The plan includes developing an additional capacity for 10 new crisis beds, based on a statewide assessment of gaps in the crisis intervention system.

### *Care Management*

The Futures plan includes a ***Care Management Program*** to ensure that the system can manage and coordinate access to high-intensity services so that Vermonters have access to the appropriate level of care and the system's resources are used efficiently. The system will help to ensure that the most integrated and least restrictive care consistent with safety is being delivered. The care management function will provide service coordination for individuals who cross multiple departmental, institutional and/or mental health program services. This coordination requires the development of common clinical protocols among all partners (designated agencies, diversion providers, designated hospitals, Corrections, etc.), the ability to convey common information for clinical services, utilization management oversight, quality improvement and conflict resolution. The care management system will create a service network that coordinates the following components:

- General hospital psychiatric inpatient beds.
- Specialized care psychiatric inpatient beds.
- Intensive care psychiatric beds.
- 18 existing mental health crisis beds.
- 10 new crisis diversion / triage beds.
- Access to the new adult outpatient capacity, for community reintegration.
- Inpatient, residential and outpatient substance abuse treatment services.

### *Peer Services, Transportation, Supportive Housing, and Legal Services*

The Futures Plan proposes new ***Peer Programming***. These services offer effective, recovery-oriented supports. The plan will create new peer support programs targeted to individuals who use VSH. Peers also will be an integral part of the provision of traditional and new services. The expansion of stand-alone peer services will also to be explored.

The plan provides resources to create secure, alternative ***Transportation*** options to the current system of using sheriffs. Additional resources for ***Transportation*** costs may be necessary as the Futures plan is implemented, due to the geographical distribution of programs.

The plan proposes new ***Supportive Housing*** resources. The lack of decent, affordable housing has been consistently identified by the Futures Advisory Group as one of the most significant unmet needs of Vermont's citizens with mental illness. There is broad consensus in the stakeholder community of providers, advocates, family members and consumers that safe and adequate housing is crucial to reducing hospitalization and supporting recovery. Therefore, housing supports will be expanded under the plan.

With inpatient hospital beds distributed in more than one location, this plan identifies the need for additional resources for ***Legal services,*** due to the need for attorneys to consult with clients and witnesses in multiple locations.

## Additional Enhancements
## Proposed by Secretary Charlie Smith
## And Supported by the Futures Advisory Committee

The context for planning the replacement of the services at Vermont State Hospital is the entire mental health service system. The Futures Advisory Group, the Legislative Mental Health Oversight Committee, and then-AHS Secretary C. Smith have viewed the successful implementation of the Futures Plan as contingent upon sustaining and enhancing the overall services system.

### *Sustaining Community Infrastructure*

Planning for the Futures Project, for both inpatient and community services, needs to occur in the context of considering the overall financial health of the designated hospital and agency service providers. The plan assumes continuation of adequate resources to sustain all existing services, including caseload growth.

### *Enhancing Community Infrastructure*

Fundamental to the plan is the recognition that a smaller, replacement inpatient unit, even with the addition of other residential programs, cannot succeed in meeting the needs of the population that VSH currently serves without enhancing the existing community mental health services infrastructure. This requires the transformation of community based and peer services into a voluntary and upstream system of supports and services that ultimately reduces Vermont's reliance on psychiatric inpatient care and involuntary care. These services need to respond to the practical needs of citizens and be appropriately dispersed geographically. In addition, this continuum of supports and services will be recovery-oriented and trauma informed.

Then-Secretary C. Smith's report to the legislature recommended developing and/or enhancing the following services.

### *Adult Outpatient Services*

Secretary C. Smith's report to the Legislature proposed new capacity for the community mental health agencies and / or private providers to provide adult out-patient service. Several different program approaches were described. These included replication of the Health Care & Rehabilitation Services of Southeastern Vermont (HCRS) program for cost-effective management of pre-CRT (Community Rehabilitation and Treatment) individuals; collaboration with the Department of Children and Families to intervene with specific TANF (Temporary Assistance for Needy Families) families on issues of depression and substance abuse; or integration of mental health care into primary care settings such as federally qualified health centers.

### *Expansion of the Co-Occurring Disorders Project*

This is a successful collaboration between the Department of Corrections and the Department of Health divisions of Mental Health and of Alcohol and Drug Abuse Programs. The two existing programs, with teams in Burlington and Brattleboro, use an evidence-based integrated mental health and substance abuse treatment approach to provide outpatient treatment to severely ill and addicted offenders. These teams combine Corrections' field staff, mental health clinicians, and substance abuse clinicians. Clients are seen daily in the community or in group treatment. Results show a markedly reduced risk of re-offense, reduction in hospital care, and positive recovery results. Additional teams are needed in Rutland and Barre.

### *Public Health Prevention and Education Strategies*

With the reorganization of the Agency of Human Services, the divisions of Mental Health, of Alcohol and Drug Abuse Programs, and of Community Public Health are now together within the Department of Health. This creates a special opportunity to apply public health, population-based prevention and early intervention techniques to the field of mental disease and substance abuse. New resources are needed to craft and communicate the public health, early intervention message with respect to mental illness. We will continue and expand on work presently being done with primary care physicians and their staffs on diagnosing and treating depression, and on making referrals to appropriate specialized services. This work will benefit from coordination with Vermont's chronic care initiative, the Blueprint for Health.

### *Offender Out-Patient Services & Mental Health Plan for Corrections*

The current capacity for the community mental health agencies and / or private providers to serve the mental health and substance abuse needs of selected offenders who are returning to the community following incarceration is widely viewed as inadequate. The development of specific mental health and substance abuse programs targeted to this population may help reduce recidivism and increase the employment and general community participation of this group. Priority will be given to interventions with a high potential of supporting the offender's long-term success.

The Futures plan builds on ongoing efforts to implement phase-in of the Corrections plan submitted by the Secretary on February 4, 2005 under the Futures legislation.

### *The Current Program at Vermont State Hospital*

Operations at the current VSH will continue until the new program capacities described in the Futures plan can be implemented. As community capacities come on line, the bed capacity at the VSH can begin to shrink. However, due to the need to enhance the current VSH staffing levels, significant staff reductions are not anticipated. The investments made now in the staff and resources at the current VSH, along with the psychiatric services being provided by Fletcher Allen Health Care, will assist in a seamless transition towards an excellent, state-of-the-art psychiatric inpatient service in the future. VSH has established a strategic plan to implement the specific recommendations made in a review by Fletcher Allen Health Care. This plan has been updated to include the requirements of the Department of Justice, licensing conditions by the Vermont Board of Health, and meeting certification requirements under CMS or JCAHHO.

### *The Continued Planning Process*

The Futures Advisory Committee will continue to be the lead multi-stakeholder group providing feedback and advice on the planning and implementation of the Futures project. This committee is advisory to the Secretary of the Agency of Human Services and is staffed by the (DMH). The Futures Advisory Committee membership represents the advocate, consumer, family, provider, and labor interests of the mental health community. This committee fulfills the legislative intent regarding the importance of broad stakeholder involvement in the Futures project.

## Decision Points

## For the Legislative Mental Health Oversight Committee

| | |
|---|---|
| 1. Approval of the overall scope and direction of the plan, as represented. Support for FY 07 appropriations request. | March 2006 |
| 2. Review of the actuarial study findings, approval for inpatient bed capacity to be developed. | June 2006 |
| 3. Approval to proceed with identified options or direction for alternatives. Considerations for the committee include<br><br>*What is the estimated size, cost and location of the proposed facility? Is it appropriate to the need and affordable to the state? What other options could be explored as alternatives, and why have they been rejected at this stage?* | June 2006 |
| 4. Authorization to proceed with the Requests for Proposals to select the architectural / engineering team to continue with the design process. | April 2006 |
| 5. Release of the second installment of the FY'06 / FY'07 capital appropriations, as per presentation of needs by the Department of Buildings and General Services in order to execute the architectural / engineering contract | July 2006 |
| 6. Review plan to address VSH staff employment / benefit issues | September 2006 |
| 7. Review of collaboration agreement with Fletcher Allen (or other inpatient program), approval to proceed or identification of alternative approach Considerations for the committee include<br>*What is the plan for property ownership and facility ownership? Who will operate the facility? How will the state exercise control over operations, and what are the projected annual operating costs* | September 2006 |

# Five Year Financial Plan

| Description | Implement. Date | SFY' 07 | SFY' 08 | SFY' 09 | SFY' 10 | First Quarter SFY' 11 | Total |
|---|---|---|---|---|---|---|---|
| **Futures Plan: Ongoing Operations (Beds)** | | | | | | | |
| Community Residential Recovery: Sub Acute Level of Care | Jul 06 (16) | 3,714,842 | 3,993,455 | 4,292,964 | 4,614,937 | 1,240,264 | 17,856,462 |
| General Fund | | 1,529,772 | 1,644,505 | 1,767,843 | 1,900,431 | 510,741 | 7,353,291 |
| Federal Funds (100% Match) | | 2,185,070 | 2,348,950 | 2,525,122 | 2,714,506 | 729,523 | 10,503,171 |
| Community Residential: Secure | Jul 06 (3), Jul 07 (3) | 1,176,556 | 2,529,595 | 2,719,315 | 2,923,264 | 785,627 | 10,134,357 |
| General Fund | | 484,506 | 1,041,687 | 1,119,814 | 1,203,800 | 323,521 | 4,173,328 |
| Federal Funds (100% Match) | | 692,050 | 1,487,908 | 1,599,501 | 1,719,464 | 462,106 | 5,961,029 |
| Crisis Beds | Jan 07 (4), Jul 07 (2), Jan 08 (4) | 212,836 | 916,662 | 1,232,948 | 1,325,419 | 356,206 | 4,044,072 |
| General Fund | | 87,646 | 377,482 | 507,728 | 545,808 | 146,686 | 1,665,349 |
| Federal Funds (100% Match) | | 125,190 | 539,181 | 725,220 | 779,612 | 209,521 | 2,378,723 |
| **Total** | | 5,104,234 | 7,439,713 | 8,245,227 | 8,863,619 | 2,382,098 | 32,034,892 |
| **General Fund** | | 2,101,924 | 3,063,674 | 3,395,385 | 3,650,039 | 980,948 | 13,191,968 |
| **Federal Funds** | | 3,002,310 | 4,376,039 | 4,849,843 | 5,213,581 | 1,401,150 | 18,842,923 |
| **Futures Plan: Ongoing Operations (Programs)** | | | | | | | |
| Care Management | | | | | | | |
| IT Design & Software (45% Match) | Jul-06 | 187,775 | 0 | 0 | 0 | 0 | 187,775 |
| Clinical Staffing for Care Mgt. (100% Match) | Oct-06 | 140,445 | 196,623 | 275,272 | 385,381 | 103,571 | 1,101,292 |
| General Fund | | 195,908 | 80,969 | 113,357 | 158,700 | 42,651 | 591,585 |
| Federal Funds | | 132,312 | 115,654 | 161,915 | 226,681 | 60,921 | 697,482 |
| Peer Support Programming ( Not Match) | Feb-07 | 79,961 | 230,266 | 247,536 | 266,101 | 71,515 | 895,379 |
| General Fund | | 79,961 | 230,266 | 247,536 | 266,101 | 71,515 | 895,379 |

| Description | Implement. Date | SFY' 07 | SFY' 08 | SFY' 09 | SFY' 10 | First Quarter SFY' 11 | Total |
|---|---|---|---|---|---|---|---|
| Staff-Secure Transportation for Involuntary Adult Admissions | Jul-06 | 94,960 | 102,082 | 109,738 | 117,969 | 31,704 | 456,453 |
| General Fund | | 67,032 | 72,060 | 77,464 | 83,274 | 22,380 | 322,210 |
| Federal Funds (50% Match) | | 27,928 | 30,022 | 32,274 | 34,695 | 9,324 | 134,243 |
| Recovery Housing | Jul-07 | | 460,532 | 495,072 | 532,202 | 143,029 | 1,630,836 |
| General Fund | | | 325,090 | 349,471 | 375,682 | 100,964 | 1,151,207 |
| Federal Funds (50% Match) | | | 135,442 | 145,601 | 156,521 | 42,065 | 479,629 |
| **Total Ongoing Operations for Futures Plan Community** | | 503,141 | 989,503 | 1,127,618 | 1,301,653 | 349,819 | 4,271,734 |
| **General Fund** | | 342,901 | 708,385 | 787,828 | 883,757 | 237,510 | 2,960,381 |
| **Federal Funds** | | 160,240 | 281,118 | 339,790 | 417,896 | 112,310 | 1,311,354 |
| **Futures Plan: Inpatient** | | | | | | | |
| Current Operational Cost | | 18,708,479 | 20,111,615 | 10,809,993 | | | 49,630,087 |
| Operations with enhancements for licensure | Jan-08 | | | 10,809,993 | 11,620,742 | | 22,430,736 |
| New Facilities | Jan-10 | | | | 11,620,742 | 6,246,149 | 17,866,891 |
| General Fund | | 18,298,479 | 19,701,615 | 16,533,236 | 12,304,972 | 3,306,961 | 70,145,262 |
| Special and IDTs | | 410,000 | 410,000 | 410,000 | 410,000 | 102,500 | 1,742,500 |
| Federal Funds (80% Match) | | 0 | 0 | 4,676,750 | 10,526,513 | 2,836,688 | 18,039,951 |
| **Capital Cost of Replacing State Hospital** | Est. in 2005 Dollars | | | 7,650,000 | 7,650,000 | | 15,300,000 |
| **Total Yearly Vermont State Hospital and Alternative Costs** | Not Including Capital Cost | 24,315,854 | 28,540,831 | 30,992,832 | 33,406,757 | 8,978,066 | 126,234,339 |
| **General Fund** | | 20,743,304 | 23,473,673 | 20,716,449 | 16,838,767 | 4,525,419 | 86,297,611 |
| **Special and IDTs** | | 410,000 | 410,000 | 410,000 | 410,000 | 102,500 | 1,742,500 |
| **Federal Funds** | | 3,162,550 | 4,657,158 | 9,866,383 | 16,157,990 | 4,350,147 | 38,194,228 |

# Vermont Mental Health Futures Plan

# Appendices

# Current Implementation Status & Outstanding Issues

This section reviews the key components of the Futures plan and progress towards implementation. It also identifies current outstanding issues and how these are proposed to be addressed. The Futures Advisory Committee meets every two months with additional special topic-focused meetings called as needed. The committee has over thirty members. The Futures Advisory Committee has also commissioned work groups to complete more detailed planning for specific program areas. Currently there are five active work groups: residential recovery, care management, facilities design, housing and human resources. All work group meetings are publicly noticed and members of the Advisory Committee are welcome to attend.

## *New, Specialized Inpatient Capacity: Role of Designated Hospitals and Site Options*

### Summary

The Futures plan proposes creating 32 new inpatient beds with two different levels of intensive treatment capability, intensive care and specialized care. This includes an estimated capacity at any given time for four to eight forensic beds to support patients in the custody of the Department of Corrections in need of inpatient care. The Futures Advisory Committee has recommended that the preponderance of beds be created at a single, primary location, preferably with Fletcher Allen on its Burlington campus. In addition, they recommend that one or two smaller capacities be created for geographic access. These smaller capacities (at Rutland Regional Medical Center and Retreat Health Care) will offer the specialized level of care and will be expected to operate under the same programmatic guidelines and standards as the primary program.

### Bed Number (Capacity)

The recommendation for 32 inpatient beds in the Futures Plan is derived from our analysis of current capacity, past utilization, and projected impact of the new residential programs to reduce the VSH census. We have also contracted for an independent actuarial study to assess the Vermont's psychiatric inpatient bed needs 10 years into the future. The actuarial study is due to be completed in mid April and is considering the following:

- The recommended bed capacity to replace VSH at two levels of inpatient care (intensive care and specialized care), 10 years into the future.
- The recommended bed capacity for general psychiatric inpatient care (the third level of care) state-wide, 10 years into the future.
- The analysis (projected bed need) will consider the impact of Vermont's community based system of care for mental health services, including the development of new programs as envisioned in the Futures Plan.
- The analysis will also consider the needs for psychiatric inpatient beds for the Department of Corrections population.

### Facility Design

Pending the completion of an actuarial study, current planning is based upon an estimated need for a capacity for 28-32 individuals at a Fletcher Allen unit. The Department of Buildings and General Services has a contract with an architectural firm, Architecture Plus (A+) to:

- Develop a preliminary "program of space needs" for the primary facility and smaller capacities;

- To identify site options and evaluate the appropriateness of these for the primary facility with FAHC, and for the smaller capacities;
- To develop a statement of probable costs for capital construction of the proposed designs at different site options.

Most of this first phase of architectural work would need to be completed regardless of site options.

A+ will conclude work by the end of June. Both Rutland Regional Medical Center and the Brattleboro Retreat are being evaluated for an added geographic capacity of specialized inpatient care. Discussions with all three hospitals are based upon capital construction costs and feasibility as well as ability to reach partnership agreements with the state.

The next stage of work will be to continue with site-specific architectural/engineering plans, construction documents, and to proceed with the permitting process. This will require BGS to initiate a Request for Proposals (RFP) to select a design team to perform these services. BGS will use the same process as before to solicit interests and award this design contract. The selection process takes approximately three to four months to complete, so this needs to begin almost immediately so that we are positioned to proceed when final decisions are made on the size and site locations for these inpatient programs.

The RFP will clearly indicate the work will not start until all agreements are in place and approvals are received from the appropriate Legislative committees. This will require the authorization to proceed with the RFP process and the subsequent release of the remaining funds in the FY 06 Buildings and General Service's appropriation and funds proposed in the FY '07 appropriation for the Futures facility development. We estimate the next stage of the design and permitting process will take at least 18 months as follows:

- Schematic Design 2 months
- Design and Development 5 months
- Construction Documents 8 months
- Bidding 3 months

**Collaboration Agreements and Host Hospitals**

The policy recommendation to site the primary facility with FAHC derives from three primary considerations:

- The desirability to integrate with tertiary-level hospital care.
- Ongoing financial sustainability (FAHC is large enough to absorb a new program without becoming an Institute for Mental Disease and is therefore eligible for Medicaid payments).
- The interest and capability of FAHC to provide a new psychiatric inpatient program (intensive care and specialized care).

The State (AHS and BGS) and Fletcher Allen are working towards a draft collaboration agreement. The first phase of work is to assess the viability of different site options on the Burlington campus for a new inpatient program. Pending the results of this analysis, a more detailed collaboration agreement will be developed or alternative site options will be explored.

The policy recommendation to create one or two smaller inpatient capacities in addition to the primary program is aimed to provide better state-wide geographic access to specialized inpatient care and to

create surge capacity within the system overall. The Futures Committee recommended that those hospitals currently operating psychiatric inpatient services be considered first for developing smaller capacities. Both Rutland Regional Medical Center and Retreat Health Care expressed interest and a commitment to work with the state to implement additional specialized inpatient capacity consistent with the operational standards of the primary facility.

**Workforce**

The current workforce at the Vermont State Hospital is uniquely skilled and qualified to provide inpatient care to Vermonters with the most severe mental illnesses. While there is wide agreement that the current physical facility at VSH is not adequate, the Futures Planning process has introduced a climate of uncertainty for VSH employees: where will the new hospital be located? if the state doesn't operate the new program, who will employ us? The AHS secretary's office is committed to working with the VSH employees to fully understand and resolve to the best of our ability the employee issues which will present themselves throughout this project. To this end AHS, the Department of Human Resources and representatives from the VSEA and VSH are forming a working group to address these concerns.

**Community Outreach**

Staff of AHS, FAHC, and the Howard Center are developing several outreach and information strategies with the larger Chittenden County community. The goal is to develop the concept of locating the new inpatient program with FAHC into a concrete proposal that is responsive to the needs and concerns of the community. To date work has begun with the Burlington City Council, the Mayor's office, and the Ward 1 Neighborhood Planning Assembly. In addition, the Chittenden County Legislative delegation has had an initial project briefing and regular dialogue sessions will be scheduled.

## *New Residential Recovery and Secure Residential Treatment Programs*

The Futures plan proposes to create two new programs designed to meet the needs of a longer-term care population currently served at VSH but who do not need inpatient-level care; residential recovery programs for sub-acute rehabilitation with a capacity of 18, and secure residential treatment with a capacity of 6. In short, the Futures plan proposes to create 24 new community residential beds. The plan called for implementing these programs in the second half of FY 06 in order to help reduce the census pressures at the current VSH and to help clarify the remaining need for inpatient capacity.

Two unsuccessful attempts to site programs in Vergennes and Greensboro have delayed implementation of these programs. Much has been learned about how to work with communities and the residents of Greensboro offered the following thoughtful summary:

- Define the population to be served, their needs, how the program will meet those needs, and the level of supervision
- Identify the characteristic in a community that would best match such a program
- Build community support with good and early communication
- Develop more accountability through an approval process for proposed programs.

We are working to implement these sound recommendations. A consortium of Designated Mental Health Agencies (DA Consortium) is working to create new program proposals in a balance of rural and town locations. The Futures Advisory Committee is providing overall guidance for program and location characteristics. Proposed programs will be considered through a process that will involve the public and advisory committee members.

## *Crisis Stabilization and Diversion*

The plan proposes to augment the existing network of ***emergency services, crisis stabilization and diversion programs*** to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization. The plan includes developing an additional capacity for ten new beds after completion of a statewide assessment of gaps in the crisis intervention system.

Materials summarizing the current capacities in the service system have been developed and distributed to the Futures Advisory Committee to help identify current gaps in the system. The FY '07 appropriations request includes funding for 4 crisis stabilization beds to begin operation in January 2007. An additional 6 beds would be created over the following 18 months. The Futures Committee has not yet provided guidance on the specific program parameters and will focus on this in upcoming meetings.

## *Care Management System*

The care management function would provide service coordination for individuals who cross multiple departmental, institutional and/or mental health program services. This coordination requires the development of common clinical protocols among all partners (designated agencies, diversion providers, designated hospitals, Corrections, etc.), ability to convey common information for clinical services, utilization management oversight, quality improvement, and conflict resolution.

A workgroup of the Futures committee has developed a set of principles to guide client movement through the system, a list of protocols to operationalize these principles, and an initial draft describing the role that each level of care plays in the overall system.

Group members are now charged with developing recommendations on admissions and discharge criteria for the new levels of care envisioned in the Futures Plan and with writing protocols to guide client placement across these care settings. In addition, the Vermont Psychiatric Survivors Inc has committed to review all the protocols from a peer resource and client rights perspective. The FY 07 appropriation requests funds to begin staffing the care management system and to create the common clinical information system needed to coordinate care across providers.

## *Supportive Housing*

Safe and adequate housing is crucial to reducing hospitalization and supporting recovery. The Futures plan proposes to create new housing and/or rental subsidies to expand access of VSH patients to affordable, safe housing.

The Futures Advisory Committee has commissioned a work group to focus on identifying what type of housing approach (new building, rent subsidy etc) would have the greatest impact on easing the housing issues for people who use VSH. The group met for the first time in early March and will develop a work plan in the near future. An appropriation requests is planned for FY 08.

## *Peer Programming*

Peer Programs offer effective, recovery-oriented supports. The Futures plan proposes new peer support programs targeted to individuals who use VSH. In addition to new peer programming, peers will be an integral part of the provision of traditional and new services.

The Futures Advisory Committee deferred work on this program area until late Spring or early summer of 2006. The FY 07 appropriations request contains partial year funding for new peer services.

## *Transportation*

As the Futures plan envisions increased geographical distribution of programs, additional resources are needed for transportation. In addition, VDH is committed to seeking the least restrictive possible means of transportation for individuals in the care and custody of the commissioner, while also ensuring patient and staff safety. The FY07 appropriation requests new resources to create secure, alternative transportation options to the current system of using sheriffs.

To this end, the Division of Mental Health staff are working to expand the alternative transportation system developed recently for children to include adults.

## *Additional Community Resources*

Secretary Charles Smith's recommendations to the Legislature included other new community capacities and underscore the importance of adequately funding the existing community mental health system. The Douglas administration has made an unprecedented commitment to a three year funding cycle for the Designated Community Agencies with consideration to annual inflationary pressures. In addition, resources for Corrections and housing are being addressed in initiatives outside of the Futures Plan.

# Scope, Values and Assumptions

## Scope of the Mental Health Futures Plan

The Vermont Mental Health Futures Plan calls for the continued transformation of our service system towards a consumer-directed, trauma-informed, and recovery oriented system of mental health. The core of the plan is the proposal for new investments in the essential community capacities that proactively meet people's needs and reduce the need for more intensive services, along with reconfiguration of the existing 54-bed inpatient capacity at the Vermont State Hospital into a new array of inpatient, rehabilitation, and residential services for adults. The fundamental goal is to support recovery for Vermonters with mental illnesses in the least restrictive and most integrated settings.

## Values and Assumptions

General:

- All people with psychiatric disabilities should have access to high quality, clinically appropriate care across the continuum of services they need to achieve and maintain recovery.
- The State must remain committed to the principle of maintaining the locus of care in the community.
- Vermont's hospitals and designated agencies (DAs) should play an expanded role in addressing needs of Vermonters appropriate to their capacities and resources.
- The State has ultimate responsibility for the provision and/or oversight of involuntary inpatient care when it is necessary.
- Vermont law directs that it be our policy "to work towards a mental health system that does not require coercion or the use of involuntary medication." (18 V.S.A. § 7629(c). At every point in our planning process, we must seek ways to reinforce a system that maximizes reasonable choices of voluntary services and avoids or minimizes involuntary treatment.

Assumptions specific to the development of new inpatient resources include:

- Recognition of the negative effects of institutional settings on a person's recovery and the importance of focusing inpatient services on those individuals who need inpatient-level care
- Recognition of the inadequacy of Vermont State Hospital's antiquated physical plant.
- Fiduciary responsibility and financial sustainability. The plan must protect long term access to federal matching funds. Therefore, a replacement inpatient facility must avoid classification as an IMD (Institute for Mental Disease) under federal regulations.
- Recognition of the benefits of integrating psychiatric inpatient care with general inpatient medical services, and of the need to end VSH's historic isolation. The provision of psychiatric inpatient services in a stand-alone IMD is not consistent with Vermont's policy of integrating mental health and general health care services.
- Recognition of the value of the expertise and experience of the current VSH staff as a resource.

# Futures Advisory Group Recommendations

In November of 2005, the Futures Advisory Group made recommendations about the scope of the needed service infrastructure and its sustainability, endorsing in concept the overall components of the Futures Plan as presented to the legislature February of 2005. It recommended that inpatient services be located in one primary site with one or two satellites for geographic accessibility, with 15 site selection criteria to guide the Secretary. As defined, the primary site recommended was Fletcher Allen Health Care. The recommendation emphasized that its support was conditioned upon continued adequate support of existing community resources as well as full budget support for the augmented service components in the proposed Futures plan. With the caveat that other primary site alternatives needed to be reviewed as options and that the selection criterion recommendations were not intended to be binding, the Futures Advisory group reiterated its support for its November vote on February 23, 2006.

The full recommendations follow.

***VSH FUTURES ADVISORY COMMITTEE***
***RECOMMENDATIONS TO SECRTARY MIKE SMITH***
***NOVEMBER 16, 2005***

The VSH Futures Advisory Committee offers the following recommendations about the sustainability of the MH Services System, the selection criteria for the inpatient service sites and partners, and the scope of the needed services infrastructure to successfully implement the Futures Plan.

"*Planning for the Futures project, for both inpatient and community services needs to occur in the context of considering the overall financial health of the Designated Hospital and Agency service providers."*

*"The VSH Futures Advisory Committee notes that its "support in concept" for the overall Futures plan, and its formal votes regarding advancing specific components, all remain contingent upon the scope of the plan as presented to the legislature last February. We do not believe that, in significant part based on prior direct experience, a replacement inpatient unit alone with or without the addition of sub acute beds can succeed in meeting the needs of the population that VSH serves. These components include the addition of emergency observation, diversion and step-down beds, additional housing, additional community services, additional peer support services, and non-traditional alternatives. It also assumes continuation of adequate resources to sustain all existing community services, including designated inpatient programs, and caseload growth. The Committee notes that the expectation is that it will see appropriate activities and funding for these components in the FY 07 budget in accordance, at a minimum, with the programs identified as and budgeted as coming on line in FY 07 in the time line that targets a new inpatient facility opening in June, 2010; and that any expedited time line would also expedite the associated program components in the budget."*

**Primary**
**Site and Partner Selection Criteria**

15. The primary VSH replacement service should not be an IMD

16. It should be attached to or near (in sight of) a tertiary / teaching hospital

17. Only designated hospital inpatient providers shall be considered for the primary VSH-replacement program until such time as it is demonstrated that an agreement cannot be negotiated with one of these partners.

18. There must be adequate space to develop or renovate a facility that will accommodate census needs.

19. The partner must agree to participate in the care management system. This assures a single standard of care, common clinical protocols, zero reject of eligible admissions etc.

20. Costs - both ongoing operations and capital construction - should be considered.

21. Outdoor activity space should be readily accessible to the units.

22. The ability to attract and retain sufficient specialty staff experienced in psychiatric care should be demonstrated.

23. The proposed partner's motivation, track record, and experience in partnering with the state and system of care should be considered.

24. Openness and past experience in including consumers/stakeholders in program design and quality monitoring should be demonstrated.

25. Willingness to participate in a public reporting of common quality standards is required.

26. Ability to deal with expedited planning time frame for full implementation to out-pace five year timeline.

27. Ability to collaborate with neighbors.

28. Ability to work closely with state and designated agency partners

29. The partner must be prepared to commit to support of the state public policy goal to work towards a system that does not require coercion or the use of involuntary medication.

**Smaller Inpatient Capacity(s)**
**Site and Partner Selection Criteria**

4. Preference should be given to Designated Hospital inpatient providers until such time as it is demonstrated that an agreement cannot be negotiated with one of these partners.

5. A location consideration is to assure adequate distribution of services throughout the state.

6. Ability to provide adequate on-site medical care and demonstrated access to hospital medical services.

*The rest of the criteria are the same as for the primary site*

7. Adequate space to develop or renovate a facility that will accommodate census needs.

8. The partner must agree to participate in the care management system. This assures a single standard of care, common clinical protocols, zero reject of eligible admissions etc.

9. Costs - both ongoing operations and capital construction - should be considered.

10. Outdoor activity space should be readily accessible to the units.

11. The ability to attract and retain sufficient specialty staff experienced in psychiatric care should be demonstrated.

12. The proposed partner's motivation, track record, and experience in partnering with the state and system of care should be considered.

13. Openness and past experience in including consumers/stakeholders in program design and quality monitoring should be demonstrated.

14. Willingness to participate in a public reporting of common quality standards is required.

15. Ability to deal with expedited planning time frame for full implementation to out-pace five year timeline.

16. Ability to collaborate with neighbors.

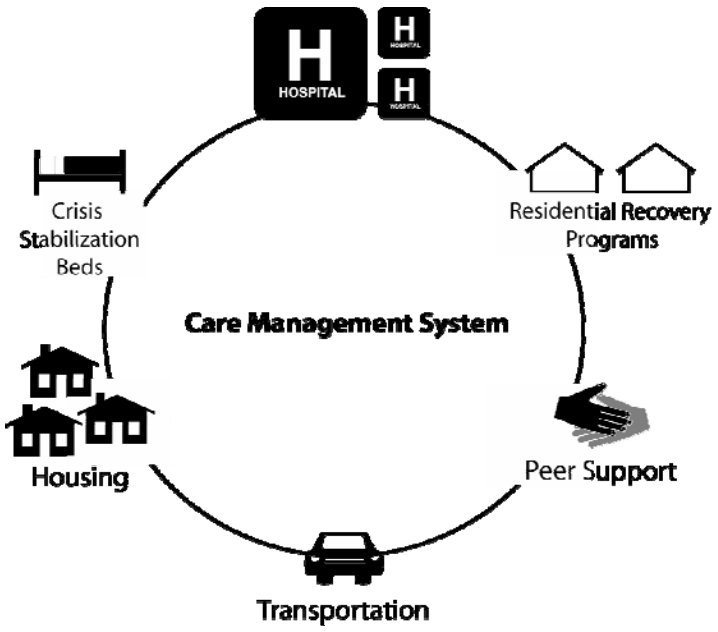
17. Ability to work closely with state and designated agency partners

18. The partner must be prepared to commit to support of the state public policy goal to work towards a system that does not require coercion or the use of involuntary medication.

# Vermont Mental Health Futures: Summary Handout

## Transforming & Sustaining a Comprehensive Continuum of Mental Care for Adults

The scope of the Futures plan is broad. It reconfigures the existing 54-bed capacity at Vermont State Hospital into a new array of inpatient, rehabilitation, and residential services for adults. The plan also calls for significant investments in the core community capacities that proactively meet people's needs, reducing our reliance in inpatient services. The plan calls for the continued transformation of our service system towards a trauma-informed, recovery-oriented, voluntary system of supports.




### General Assembly, FY 06 Appropriation

The General Assembly directed that

• The current VSH facility should be replaced with a facility or facilities with fewer than 54 beds and with meaningful programmatic integration of medical and community mental health services.

• The operations and human resources of the current VSH must be supported and enhanced so that the environment is safe and the clinical programming effectively supports recovery.

• The capacity and network of community support services should be expanded to help meet needs in a clinically appropriate manner and in keeping with system values.

### Service Components

• New **Inpatient Care,** including intensive care and specialized care inpatient programs (estimated capacity of 32 beds) with more intensive staffing patterns than currently exist at VSH or in community hospital psychiatric units.

• **Crisis Stabilization Beds** (10 beds) in geographically dispersed locations to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization.

• A **Care Management Program** to ensure that the system can manage and coordinate access to high-intensity services, so that Vermonters have access to the appropriate level of care and the system's resources are used efficiently.

• New **Residential Recovery Programs** designed to meet the needs of a longer-term care population currently served at VSH but who do not need inpatient-level care or a secure setting. (capacity of 16-22).

• New **Transportation Services** (alternative to sheriff transport; additional resources), **Peer Support**, and **Housing.**

### Current Work in Process (3/06)

• Architectural review to define space needs, to identify and evaluate site options for inpatient facility, to begin development of schematic plans, and to develop statements of probable costs for the various site options.

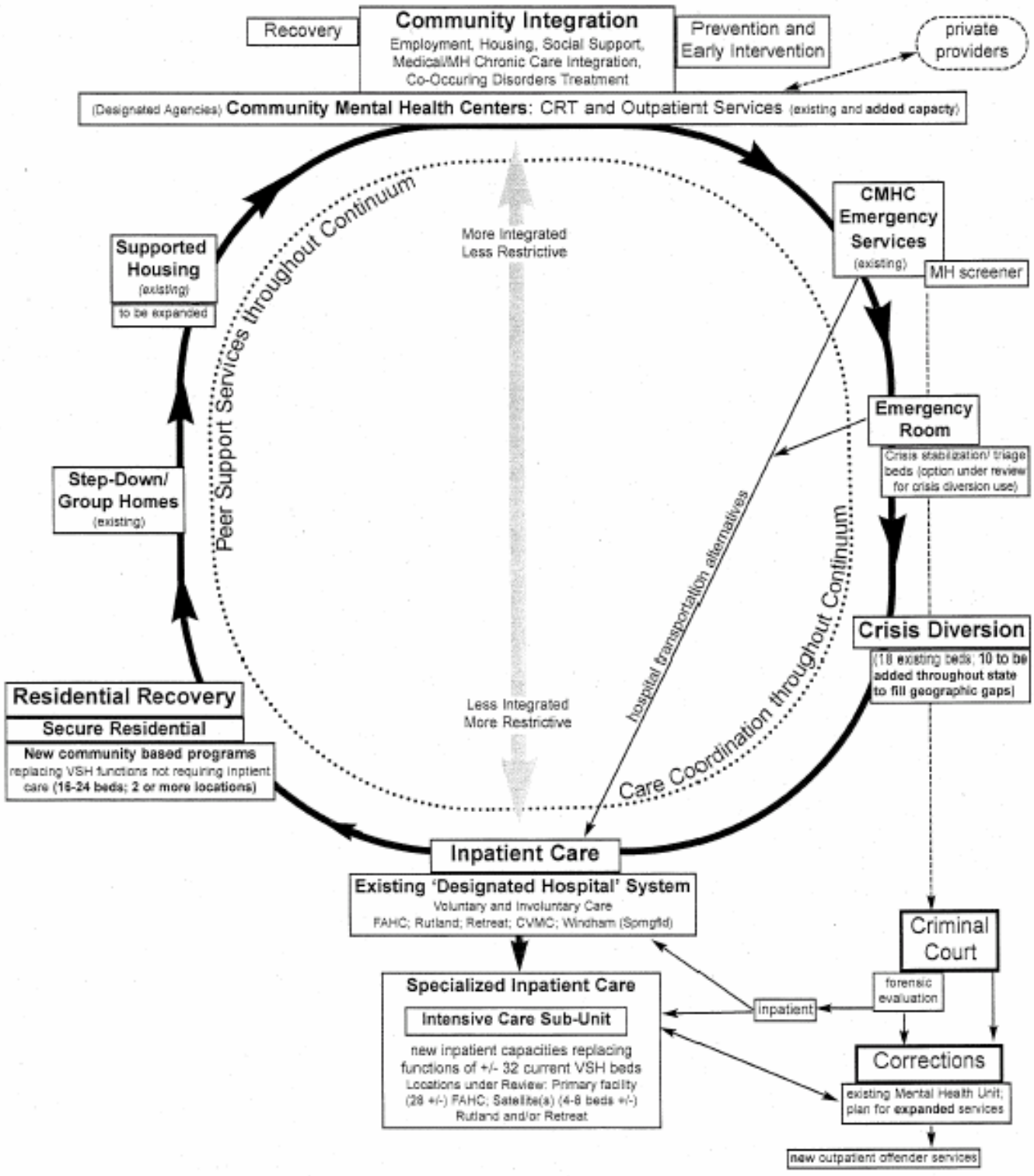
• Negotiations with inpatient (FAHC, Retreat Health Care, RRMC) partners

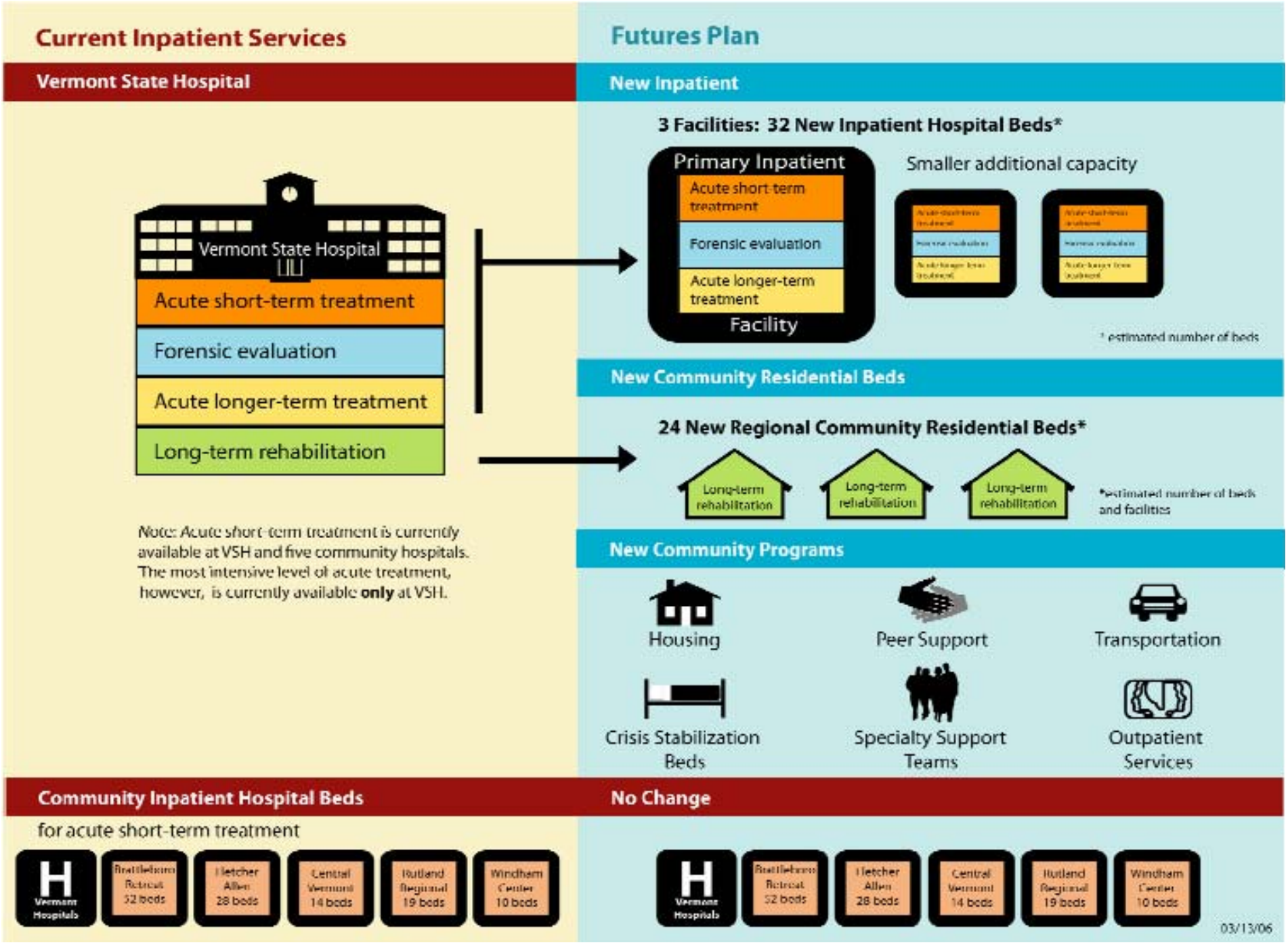
• Actuarial study to provide independent projection of psychiatric inpatient beds needs 10 years into the future

• Design and site identification for community residential recovery programs

• Design for a care management system

## Overview of the Transformed System: The Futures Plan




Current Inpatient Services
Vermont State Hospital
Vermont State Hospital
Acute short-term treatment
Forensic evaluation
Acute longer-term treatment
Long-term rehabilitation
Note: Acute short-term treatment is currently available at VSH and five community hospitals. The most intensive level of acute treatment, however, is currently available only at VSH.
Futures Plan
New Inpatient
3 Facilities: 32 New Inpatient Hospital Beds*
Primary Inpatient
Acute short-term treatment
Forensic evaluation
Acute longer-term treatment
Facility
Smaller additional capacity
* estimated number of beds
New Community Residential Beds
24 New Regional Community Residential Beds*
Long-term rehabilitation
Long-term rehabilitation
Long-term rehabilitation
*estimated number of beds and facilities
New Community Programs
Housing
Peer Support
Transportation
Crisis Stabilization Beds
Specialty Support Teams
Outpatient Services
Community Inpatient Hospital Beds
for acute short-term treatment
Vermont Hospitals
Brattleboro Retreat 52 beds
Fletcher Allen 28 beds
Central Vermont 14 beds
Rutland Regional 19 beds
Windham Center 10 beds
No Change
Vermont Hospitals
Brattleboro Retreat 52 beds
Fletcher Allen 28 beds
Central Vermont 14 beds
Rutland Regional 19 beds
Windham Center 10 beds
03/13/06

# VERMONT FUTURES
# STRATEGIC IMPLEMENTATION PLAN
## TRANSFORMING AND SUSTAINING A COMPREHENSIVE CONTINUUM OF MENTAL HEALTH CARE FOR ADULTS

February 2005 – June 2010

Working Plan: March 2006
(List of Abbreviations at end)

## PLAN OVERVIEW

***Basis and Scope*** This implementation plan is based on the Designated Agency Sustainability Study, the Vermont State Hospital Futures Plan: Report to Secretary Smith and Secretary Smith's Recommendations for the Future of Services Provided at Vermont State Hospital to the Legislature, the Health Resources Allocation Plan (H-RAP) and the State Health Plan. The scope of this implementation plan is quite broad; it reconfigures the existing 54-bed capacity at VSH into a new array of inpatient, rehabilitation, and residential services for adults. The plan also calls for significant investments in the core community capacities that proactively meet people's needs thereby reducing our reliance in inpatient services. In addition, the Futures implementation plan calls for the continued transformation of our service system towards a trauma-informed, recovery oriented, and voluntary system of supports. Finally, this plan identifies the major decision points, implementation milestones, estimated resources needed, and process for stakeholder input in the design and implementation of programs.

***Values and Assumptions Informing This Plan***

- All people with psychiatric disabilities should have access to high quality, clinically appropriate care across a broad continuum of services.
- Widespread recognition of the negative effects of institutional settings on a person's recovery, and of the inadequacy of VSH's antiquated physical plant.
- The scheduled loss of federal funds due to federal policy changes affecting all of the country's institutes for mental disease (IMDs), of which VSH is one.
- Widespread recognition of the benefits of integrating psychiatric inpatient care with general inpatient medical services, and of the need to end VSH's historic isolation. Therefore, the provision of psychiatric inpatient services in a stand-alone IMD is not consistent with Vermont's policy of integrating mental health and general health care services.
- The State has ultimate responsibility for the provision and/or oversight of involuntary inpatient care.
- The expertise and experience of the current VSH staff is a valuable resource.
- Vermont's hospitals and designated agencies (DAs) should play an expanded role in the future care of discrete populations.
- The State must remain committed to the principle of maintaining the locus of care in the community.

***Summary Conclusions*** The following statements summarize a general consensus among stakeholders as of June 2005 and this language was approved by the General Assembly.

**1. The current VSH facility should be replaced; replacement facility or facilities will be smaller than 54 beds; and should be operated with meaningful programmatic integration with medical and ongoing community mental health services.**
**2. The operations and human resources of the current VSH must be supported, and enhanced so that the environment is safe and the clinical programming effectively supports recovery.**
**3. The network of community support services and capacities should be expanded to help meet needs in a clinically appropriate manner and in keeping with system values.**

## PLAN COMPONENTS

- Transforming the Acute Care System
  - Recovery Residential Programs (Sub Acute Rehabilitation Capacity)
  - Secure Residential Treatment Capacity
  - New Inpatient Capacity
  - Crisis Stabilization Beds
  - Care Management System
- Sustaining and Building the Operations at VSH
- Enhancing Community Infrastructure
  - Peer Services
  - Supported Housing
  - Transportation (Voluntary and Involuntary)
  - Ancillary Legal Services

## OVER ARCHING COMPONENTS

### Develop Vision / Description of a Comprehensive Continuum of MH Services

| Action Steps & Decision Points | Timeline | Key Players |
|---|---|---|
| **Review proposed phasing of program implementation** | 2005 | |
| Create overall system design including component parts | July | |
| Revise phasing based on input | | VDH, VSHFAC |
| **Identify key system gaps by component and geography** | September | VDH, VSHFAC, VCDMH, SPSC, private providers/payers' |
| Revise plan & work group approach as needed | September | VSHFAC, MHOC |
| | November | |
| | December, ongoing | VDH |

## TRANSFORMING THE ACUTE CARE SYSTEM

***SERVICE COMPONENTS RECOMMENDED IN THE FUTURES PLAN***

The Futures plan calls for the development of the new levels of inpatient care and new crisis stabilization or acute care triage resources. Specifically, two new levels of **inpatient care** called intensive care and specialized care (estimated capacity of 32 beds) are proposed both of which reflect more intensive staffing patterns than currently exist at VSH or in Designated Hospital programs. In addition, the plan proposes ***Crisis stabilization beds*** (10 beds) in geographically dispersed locations to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization. The Futures plan also envisions a ***Care Management Program*** to ensure that the system can manage and coordinate access to high intensity services so that Vermonters have access to the appropriate level of care and the system's resources are used efficiently. Finally, the plan proposes to create two new programs designed to meet the needs of a longer-term care population currently served at VSH but who do not need inpatient-level care **recovery residential programs at the s*ub-acute level of care*** capacity of 16-20) and ***secure residential treatment*** (capacity of 6).

### Residential Recovery Programs (Sub Acute Rehabilitation Capacity)

| Action Steps & Decision Points | Timeline | Key Players |
|---|---|---|
| | 2005 | |
| FY 06 Appropriation request $763,400 G.F. | February | VDH CFO, AHS Secretary |
| Engage designated providers in program development | March<br>June | VCDMH, Adult MH Director |
| **Clarify BISCHA Jurisdiction for CON** | June | VDH Chief Attorney |
| **FY 07 Appropriation Development $1,526,800**[58] | October | VDH CFO, AHS Secretary |

[58] This represents annualization of initial appropriation. Actual program implementation costs may be higher. As no programs are currently operational, VDH CFO recommends addressing this in budget adjustment process.

| | | |
|---|---|---|
| Resolve legal status of program (voluntary, involuntary) and of program residents | December | Residential Work Group, VDH, Chief Attorney |
| | 2006 | |
| Identify potential site locations | | |
| Refine programmatic characteristics | Ongoing | DA Leadership, Residential Work Group |
| | Ongoing | |
| **Solicit feedback on site locations and program characteristics** | Ongoing | SPSC & LPSCs; VSHFAC; MHOC |
| Request scheduling guidelines for ONH Modification/Revocation | | Chief Attorney, Residential Work group DA Leadership |
| Request necessary zoning permits, engage local communities in program plans and solicit feedback | April Ongoing | DA Leadership, MH Deputy |
| Recruit and train staff | | DA Leadership |
| Begin transition of VSH patients | | VSH & DA Clinical Teams |
| Evaluate program | Prior to Start-up | DA Leadership, VDH, VSHFAC |
| **Secure Residential Treatment Capacity** | | |
| Action Steps and Decision Points | Timeline | Key Players |
| | 2005 | |
| **FY 06 Appropriation request $241,782 G.F.** | February | VDH CFO, AHS Secretary |
| Engage designated providers in program development | March | VCDMH, Adult MH Director |
| **Clarify BISCHA Jurisdiction for CON** | June | VDH Chief Attorney |
| Identify potential site locations | Ongoing | DA Leadership, Residential Work Group |
| Refine programmatic characteristics | Ongoing | SPSC & LPSCs; VSHFAC; MHOC |
| **Solicit feedback on site locations and program characteristics** | Ongoing | |
| **FY 07 Appropriation Development $483,564 G.F.** | Ongoing October | VDH CFO, AHS Secretary |
| Refine security and staffing plans | 2006 March-May | Residential Work Group, VDH, Chief Attorney |
| Rent single family home/apartments | June | DA Leadership |
| Develop protocols with local law enforcement | May-June | DA Leadership |
| Recruit and train Staff | June | DA Leadership |
| Begin transition of VSH patients | Ongoing | DA Leadership |
| **New Inpatient Capacity** | | |
| Action Steps and Decision Points<br>Phase 1: Planning & Site Selection | Timeline<br>7/05-6/06 | Key Players |
| | 2005 | |
| **FY 06 Appropriation request $625,000 G.F.** | February | VDH CFO, AHS Secretary VSHFAC |
| **Formalize creation of Inpt work group** | August | VDH |
| Identify pro's and con's of single vs multiple sites | | |
| **RFP for Architectural Services** | October | Inpt Work Group, VSHFAC, MHOC |
| **Preliminary Space Program, Site Feasibility and Cost** | November | B&GS |
| **RFP for Actuarial Services** | | |
| **Develop recommendation for single or multiple sites** | November December | VDH, Inpt Work Group VSHFAC |

| | | |
|---|---|---|
| **Develop recommendation for inpatient partner(s)** | | VDH CFO, AHS Secretary |
| **Contract for Architectural Services** | By Dec | MH Deputy, Inpt Work Group |
| | December | B&GS, A+ |
| **FY 07 Appropriation request $1,350,000 for continued planning & design** | 2006 | |
| Identify options of inpatient partner(s) | January | |
| | | B&GS |
| **Contract for actuarial services** | January | MH Deputy |
| **Develop Program of Space for Primary and Smaller Inpatient Capacities** | January | VDH staff, Selection Committee |
| | Jan-March | B&GS, A+, Facilities Work Group |
| **Develop Collaboration Agreements w/Inpatient Partners** | | VSHFAC, VDH |
| | Jan-June | VDH,AHS,Inpt Partners |
| **Develop Community Outreach** | Ongoing | |
| | February | VDH, City of Burlington, FAHC Futures |
| **Develop Feasibility Assessment & Cost of Site Options** | Ongoing | Group |
| | Feb-May | B&GS, A+ |
| Conduct actuarial study (completed) | | Inpt Partners & MH Deputy |
| **Refine bed capacity needed** | April | VDH, Milliman |
| Submit Letter of Intent to BISHCA | April | VDH, VSHFAC,AHS |
| **Identify site for primary unit, permitting requirements, design work** | May | VDH, Inpt Partner(s) |
| | May-Oct | B&GS, VDH, Inpt Partner, VSHFAC |
| **Identify renovation/construction needs for smaller inpatient capacities** | Ongoing | |
| | | A+, B&GS, VDH, Inpt Partners |
| **Conceptual CON application** | Feb-May | |
| | | VDH, Inpt Partner, VDH Chief Attorney |
| CON Q&A, Interested Parties, Due Diligence | June | BISHCA, VDH, Inpt Partner(s) |
| ***Phase II architectural and engineering studies, Permitting** | Aug-Oct | B&GS, Inpt Partners |
| **FY 08 Appropriation request** | Aug-Dec | |
| (based on estimates completed May 06) | | B&GS, VDH, AHS |
| Public process for construction (zoning, select board) | October | |
| | | B&GS, VDH, AHS, Inpt Partner |
| *Conflicts with time line for Conceptual CON | Aug-Dec, Ongoing | |
| Action Steps and Decision Points<br>Phase 2: Design and CON | Timeline<br>7/06-12/07 | Key Players |
| | 2006 | |
| *Draft Construction Drawings | November | Contractor |
| **Solicit feedback on draft drawings** | December, Ongoing | SPSC, VSHFAC, Burlington Futures, Legislature |
| *Local permitting process | Ongoing | Inpt Partner, B&GS, |
| **Conceptual CON awarded** | December | BISHCA |

| | | |
|---|---|---|
| | 2007 | |
| Local permits and begin Act 250 process | January, Ongoing | Inpt Partner, VDH Chief Attorney |
| Select contractor determine building process | January | Inpt Partner, Buildings & General Services |
| **Submit full application to BISHCA for CON (site and architectural plans schematic label; basic electrical and mechanical engineering details - sufficient for BISHCA)** | January | Inpt Partner, VDH Chief Attorney |
| Submission to & review of additional information by BISHCA | February-April | Inpt Partner, VDH Chief Attorney, BISHCA staff |
| BISHCA Rules "Application Complete" and issues public notice for competing applications, interested party status or Amicus Curiae | May | |
| Public oversight commission hearing date scheduled | June | BISCHA Commissioner<br>BISHCA Staff |
| Commissioner BISHCA makes final determination of CON | August | BISCHA Commissioner |
| Action Steps and Decision Points<br>Phase 3: Construction & Program Design | Timeline<br>8/07-1/10 | Key Players |
| Groundbreaking | | Building Contractor |
| Construction | | Building Contractor |
| Initial program design | | Inpt Partner, VDH, VSH Staff |
| | | SPSC, Partner Advisory Groups, legislature |
| **Solicit feedback on program design** | | Inpt Partner, VDH, VSH Staff |
| Revise program design | | |
| Action Steps and Decision Points<br>Phase 4: Program Implementation | Timeline<br>8/09-1/10 | Key Players |
| Staff Recruitment and Training | | Inpt Partner, VSH staff |
| Clinical and Program Characteristics Refined | | Inpt Partner, VSH staff |
| **Crisis Stabilization Beds** | | |
| Action Steps and Decision Points | Timeline | Key Players |
| | 2005 | |
| **FY 07 Appropriation Request Development** | October | VDH CFO, AHS Secretary |
| Clarify Role of these Beds w/ Emergency Directors & local stakeholders including Public Inebriate use ? | November, Ongoing | VSHFAC, VCDMH, VDH, CM Work Group |
| Complete geographic analysis for proposed locations | November | |
| | 2006 | |
| **Solicit Feedback on program roles & on proposed locations** | February-March | VSHFAC, SPSC, MHOC<br>VDH<br>VSHFAC |
| **FY07 Appropriation Request $87,646** (4 beds, 6 months operations) | January | AHS |
| | April | DA Leadership |
| Solicit program development options in target areas | | VSHFAC, SPSC, MHOC |
| | August | DA Leadership |
| Refine programmatic characteristics | September | VSHFAC |
| **Solicit feedback on program characteristics** | October | DA Leadership |
| Revise program plans | October | VDH, AHS |

| | | |
|---|---|---|
| **Develop FY 08 Appropriation Request** (6 new beds, annualization of 4 beds)<br>Recruit and train staff | November<br><br><u>2007</u> | DA Leadership |
| Program start up (4 beds) | January<br><br>March | DA Leadership<br><br>VDH, DA Leadership |
| Solicit program development options in target areas (6 new beds | | |
| Refine programmatic characteristics<br>**Solicit feedback on program characteristics**<br>Revise program plans | May<br>June<br>July | VDH, DA Leadership, VSHFAC<br>DA Leadership |
| Recruit and Train Staff | September, ongoing | DA Leadership |
| **Develop FY 09 Appropriation Request**<br>Program Start-Up | October<br>December | VDH, AHS Secretary<br>DA Leadership |

## Care Management System

| Action Steps and Decision Points | Timeline | Key Players |
|---|---|---|
| | <u>2005</u> | |
| **Formalize Identification of CM Work Group**<br>**FY 07 Appropriation Request Development Estimate $300,000** | July | VSHFAC |
| | October | VDH CFO, AHS Secretary |
| Develop program design, screening, triage, disposition protocols in collaboration with stakeholders | December<br><u>2006</u> | CM Work Group |
| **Solicit feedback on program design**<br>**FY 07 Appropriation Request $161,112** (partial yr operations) | January<br>January | VSHFAC, SPSC, LPSCs, MHOC |
| Refine program design | March | CM Work Group |
| Define IT System support needs | April | CM Work Group |
| Design management approach and staffing plan | June | CM Work Group |
| Design IT system | July | Contractor (likely) |
| Pilot protocols | August | Participating partners |
| Revise protocols based on pilot | September | CM Work Group |
| Implement | October | Participating partners |

## Sustaining & Building the Operations at VSH

### *The current program at Vermont State Hospital*

Operations at the current VSH will continue until the new program capacities described in the Futures plan can be implemented. As community capacities come on line, the bed capacity at the VSH can begin to shrink. However, due to the need to enhance the current VSH staffing levels, significant staff reductions are not anticipated. The investments made now in the staff and resources at the current VSH will assist in building towards an excellent, state-of-the-art psychiatric inpatient service in the future.

| Action Steps and Decision Points | Timeline | Key Players |
|---|---|---|
| | 2005 | |
| Develop enhanced staffing plan | February | VSH leadership |
| **FY 06 Appropriation Request $16,001,347 G.F.** | March | VDH CFO, AHS Secretary |
| Design staff recruitment & retention package | April | VSH Leadership, AHS Deputy |
| Implement staffing pattern | Ongoing | VSH leadership |
| Develop Fletcher Allen contract for psychiatry svcs | May | VDH leadership |
| **Approve Fletcher Allen Contract** | June | VDH Commissioner, Administration, VSH Governing Body |
| Continue facility improvements | Ongoing | VSH leadership, Buildings and General Svcs |
| Continue improvements to Clinical and Quality Systems | Ongoing | FAHC, VSH Leadership, VSH Governing Body MHOC |
| **Develop FY 07 Appropriations Request** | October | VDH CFO, AHS Secretary |

## Enhancing Community Infrastructure

### *SERVICE COMPONENTS RECOMMENDED IN THE FUTURES PLAN*

The Futures Plan calls for the transformation of community based and peer services into a voluntary and upstream system of supports and services that ultimately reduces Vermont's reliance on psychiatric inpatient care and involuntary care. These services need to respond to the practical needs of citizens and be appropriately geographically dispersed. In addition, this continuum of supports and services will be recovery-oriented and trauma informed. Specifically the Futures Plan calls for the development of the following new services.

***Supportive Housing*** safe and adequate housing is crucial to reducing hospitalization and supporting recovery. ***Peer Programming*** offers effective, recovery-oriented supports. The plan proposes to create new peer support programs targeted to individuals who use VSH. In addition to new peer programming, peers can and should be an integral part of the provision of traditional services. This area, both stand alone peer services, and the integration of peers into formal services needs more exploration. This plan includes funding for ***Transportation*** costs, made necessary by the geographical distribution of programs. If the inpatient hospital beds are distributed in more than one location, this plan includes additional resources for ***Legal services***, due to the higher costs of having attorneys consult with clients and witnesses in multiple locations.

### *Additional Recommendations by Secretary Charles Smith to the Legislature*

Secretary Charles Smith's February 4th recommendations to the Legislature included additional program capacities not named in the Futures Plan. These include the implementation of the Mental Health Plan for Corrections and other community-based mental health services designed to strengthen the outpatient and co-occurring treatment infrastructure. Specifically these are:

***Adult Outpatient Services*** added capacity for the community mental health agencies and / or private providers to provide adult out-patient service. Examples might include:

- A program focused specifically on the mental health needs of service men and women returning from a war zone, and / or their families during the deployment;
- Replication of the HCRS (Health Care & Rehabilitation Services of Southeastern Vermont) program for cost-effective management of pre-CRT (Community Rehabilitation and Treatment) individuals;
- Collaboration with the Department of Children and Families to intervene with specific TANF (Temporary Assistance for Needy Families) families on issues of depression and substance abuse.
- Integration of mental health care into primary care settings such as federally qualified health centers.

***Offender Out-Patient*** calls for capacity for the community mental health agencies and / or private providers to serve the mental health and substance abuse needs of selected offenders who are returning to the community following incarceration with priority given to interventions with a high potential of supporting the offender's long-term success.
***Expansion of the Co-Occurring Disorders Project*** This is a successful collaboration between the Department of Corrections and the Department of Health divisions of Mental Health and of Alcohol and Drug Abuse Programs. Using integrated mental health and substance abuse treatment, teams in Burlington and Brattleboro provide outpatient treatment to severely ill and addicted offenders. These teams combine Corrections' field staff, mental health clinicians, and substance abuse clinicians. Clients are seen daily in the community or in group treatment. Results show a markedly reduced risk of re-offense, reduction in hospital care, and good recovery results. Two new teams are proposed, in

Rutland and Barre.

***Public health prevention and education strategies*** with the reorganization of the Agency of Human Services, the divisions of Mental Health, of Alcohol and Drug Abuse Programs, and of Community Public Health are now together within the Department of Health. This creates a special opportunity to apply public health, population based prevention and early intervention techniques to the field of mental disease and substance abuse. New resources will be used to craft and communicate the public health, early intervention message with respect to mental illness. We will continue and expand on work presently being done with primary care physicians and their staffs on diagnosing and treating depression, and on making referrals to appropriate specialized services. This work will benefit from coordination with Vermont's chronic care initiative, the Blueprint for Health.

## Peer Services

| Action Steps and Decision Points | Timeline | Key Players |
|---|---|---|
| | 2005 | |
| **Develop FY 07 Appropriations Request $200,000 G.F.** | October | VDH CFO, AHS Secretary |
| | 2006 | |
| **FY 07 Appropriation Request $79,961 (partial yr operations)** | | |
| Develop program approach | May -Sept | VPS, SPSC, VSH FAC |
| **Solicit input on program approach** | October | VSHFAC, LPSCs, MHOC |
| **Develop FY 08 Appropriation Request (C. Smith Recommend $200,000)** | October | VPS<br>VDH, AHS |
| Solicit proposals from peer organizations | November | SPSC (consider) |
| Review proposals | December | SPSC or Ad Hoc Review Committee |
| | 2007 | |
| Develop contract | January | VDH |
| Program start up | February | Contractor |

## Supported Housing

| Action Steps and Decision Points | Timeline | Key Players |
|---|---|---|
| | 2006 | VDH CFO, AHS Secretary |
| **Solicit input on program approach** | January | |
| **Identify location based on geographic need** | | VCDMH, VPS, SPSC |
| **Form Workgroup** | February | VSHFAC, LPSCs, MHOC |
| Develop Program approach | March-June | Workgroup |
| Depending on program approach: | | |
| Determine viability of HUD or other funding options | June-Ongoing | Workgroup, VSHFAC |
| Identify sites, renovation / acquisition costs | | VDH |
| Identify Providers (depends on program approach) | | VDH |
| Next steps based on decisions above | | VDH |
| Or: | June-Ongoing | |
| Design rental subsidy / assistance program | | |
| | October | |
| **Develop FY 08 appropriation request (C. Smith recommend $400,000)** | 2007 | VDH, AHS |
| | Jan-March | |
| | January | |
| **Design Program** | April | VDH, Work Group, VSHFAC |
| **FY O8 Appropriation** | July | AHS,VDH |
| **Solicit Program Bids** | | Work Group, VDH |
| **Program Start-up** | | DA, Contractor |

| Transportation (Voluntary and Involuntary) | | |
|---|---|---|
| **Action Steps and Decision Points** | **Timeline** | **Key Players** |
| **Develop FY 07 Appropriations Request $67,032** | 2005<br>October | VDH CFO, AHS Secretary |
| | 2006<br>March | |
| Develop safety guidelines | April-May | Sheriffs, MH Emergency Directors, NAMI, VPS |
| Identify alternative transport options | June-August | VDH |
| Negotiate contracts | September | |
| | October | VDH, Emergency Directors |
| Train on approach, pilot | November | VDH, Emergency Directors |
| Evaluate efficacy, revise as needed | | VDH |
| Start Up | | VDH, Emergency Directors, Contractor |

| Ancillary Legal Services | | |
|---|---|---|
| **Action Steps and Decision Points** | **Timeline** | **Key Players** |
| | 2006 | |
| Identify potential changes | October | VDH Chief Attorney, Legal Aid, VT P&A |
| **Work group recommended?** | November | VDH Chief Attorney, Legal Aid, VSHFAC |
| **Statutory changes required?** | November | VDH Chief Attorney, Legal Aid, VSHFAC |
| (next steps dependent on above) | | |
| Quantify impact of potential changes to legal system | | |

## Sustaining Community Infrastructure

The Designated Agency Sustainability Study, conducted in the Fall of 2004, made several recommendations regarding the effectiveness and sustainability of the Designated Agency network for the provision of community mental health, developmental, and alcohol and drug treatment services. Based on this report, AHS Secretary Charles Smith recommended that a multi-year budget planning cycle be developed. Below are the specific action steps he recommended.

| Action Steps and Decision Points | Timeline | Key Players |
|---|---|---|
| | 2006 | |
| Develop Allocation Agreement Between Cost of Living Adjustment and Service Growth Requirements | February | VDH, DAIL, VCDMH |
| Identify Medicaid Maximization Opportunities / Risks | March | VDH, DAIL, VCDMH |
| Target Resources to Adult Outpatient, Emergency, and Substance Abuse Programs | Ongoing | DA Providers |
| Start DA Designation Cycle | March | VDH, DAIL, VCDMH |
| | | VDH, DAIL |
| Establish FY 07 Allocations and Performance Contracts | July | VDH, VCDMH |
| | 2007 | |
| | January 07 | OVHA, SPSC, (others) |
| Begin System Improvement Process to: | | |
| - Develop comparable financial and performance data across DA providers | TBD | VDH, DAIL, VCDMH, SPSC, LPSCs |
| - identify redundancy in data collection procedures | | |
| - Focus data collection on most impactful measures of system performance and client outcomes | | |
| - Establish, with stakeholders, clear performance expectations | | |
| - Design consistent "therapeutic thresholds" and individual case plans | | |
| - Vermonters with comparable needs will receive comparable services regardless of DA provider | | |

| | | |
|---|---|---|
| - Develop case mix factors for DA budget allocation<br>- Apply case mix concepts to annual performance contracts | | |

List of Abbreviations:

| | |
|---|---|
| **H-RAP** | Health Resource Allocation Plan |
| **VDH** | Vermont Department of Health |
| **VSH** | Vermont State Hospital |
| **IMD** | Institute for Mental Disease (stand alone psychiatric hospital or program) |
| **DA** | Designated Agency to provide comprehensive mental health services in a defined geographic region |
| **ICU** | Intensive care (inpatient) |
| **SIP** | Specialized care (inpatient) |
| **BISHCA** | Banking, Insurance, Securities and Health Care Administration |
| **CON** | Certificate of Need |
| **CM Work Group** | Care Management Work Group |
| **VCDMH** | VT Council of Developmental and Mental Health Services Providers |
| **VSHFAC** | VSH Futures Advisory Committee |
| **MHOC** | Joint Legislative Mental Health Oversight Committee |
| **SPSC** | Adult Mental Health State Standing Committee |
| **LPSC** | Adult Mental Health Local Standing Committee |
| **Inpt** | Inpatient |
| **DOC** | Department of Corrections |
| **ADAP** | Division of Alcohol and Drug Abuse Programs |
| **DAIL** | Department of Disabilities, Aging and Independent Living |
| **OVHA** | Office of Vermont Health Access |
| **VPS** | Vermont Psychiatric Survivors |
| **NAMI-VT** | National Alliance for the Mentally Ill – Vermont chapter |

# Policy, Legislation, and Appropriations Flow

| POLICY Context |
|---|
| **Mental health programs, services, and supports, including inpatient psychiatric services, will be provided in a holistic, comprehensive and coordinated continuum of care.**<br>**Consumers will be treated at all times with dignity and respect.**<br>**Public resources will be allocated efficiently and produce the best positive outcomes.**<br>**The services overseen and provided by the agency of human services and its community partners will be client- and family-centered and -driven, accessible, and culturally competent.**<br>**The locus of care is the community; investments in ongoing community supports and early interventions services will reduce the need for inpatient care.**<br>**We are committed to reducing coercion in the system of care.**<br>**Mental health and substance abuse treatment will have parity with health care and we seek the integration of mental health care and health care.** |

| Time Line | Actions | Appropriation |
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| **January 26, 2004** | **Study commissioned by DDMHS Commissioner Susan Besio concludes**:<br>1. Support VSH to play a unique role in the VT public MH system<br>2. Create a new setting for VSH<br>3. Develop a financial strategy for the community services needed to reduce the demand for VSH Services | **None** |
| **May, 2004** | **FY 05 Appropriation "BIG BILL"** Sec. 141a. **Commissions the Futures Planning Process**<br>1. "The AHS Secretary shall be responsible for the development and, upon approval by the MH oversight committee and joint fiscal committee, implementation of a comprehensive strategic plan for the delivery of services currently provided by VSH.<br>2. Establishes the Futures Advisory Group and that the Secretary will consult on all aspects of strategic planning and recommendations concerning organization, operations, funding, and implementation; and sets out 9 planning principles and 13 specific areas of recommendation.<br>3. Requires a comprehensive implementation plan for replacing services currently provided by the VSH to be presented to the MH oversight committee and the joint fiscal committee | **None** |
| **February 4th 2005** | **MH Division's VSH Futures Plan** published, submitted to Legislature **Recommendations to the Legislature for the Future of Services Provided at the VSH: Secretary Charlie Smith**<br>Responds to Sec 141(a) and (b) of Appropriations Act of 2005; recommends $21,800,000 of expenditures to replace VSH direct services (28 beds plus 4); Residential Recovery programs (16-bed sub acute rehabilitation; 6-bed secure residential); new programs for: housing, care management, peer support, out patient, crisis stabilization, offender outpatient, co-occurring disorders, corrections MH services, legal and transportation services | **AHS Secretary C. Smith recommends $21,800,000** |
| **May 11, 2005** | **MH Division presents VSH Futures Strategic Implementation Plan to MH Legislative Oversight Committee**<br>This plan provides implementation timeframes and appropriations requests for all the recommendations in Secretary Charlie Smith's report as per Sec | |

| Time Line | Actions | Appropriation |
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| | 141(a) and (b) of Appropriations Act of 2005.<br><br>On recommendation of committee members, this plan was redrafted to include policy context and planning assumptions.<br><br>**Futures Advisory Committee** endorses development of sub-acute rehabilitation and secure residential services as first phase of the project | |
| **May 31, 2005** | **MH Division presents VSH Futures Planning Outline to House Human Services Committee**<br>This outline summarizes the core components of Secretary Smith's recommends to create a continuum of care in the most integrated and least restrictive environment. It offers specific recommendations for legislative approval and sets forth a proposal for phased implementation.<br><br>House Human Services Committee approves the plan and inserts language into the appropriations bill (see below) | |
| **June 2005** | **FY 06 Appropriation "BIG Bill"** Sec113e.<br>(a) The general assembly adopts the principles in the May 31, 2005 draft report from the department of health for restructuring the delivery of mental health services currently received in the Vermont state hospital, including the following:<br><br>(1) The current state hospital facility should be replaced with a facility or facilities with fewer than 54 beds and with meaningful programmatic integration of medical and community mental health services.<br><br>**FY 06 Appropriation "BIG Bill"** Sec113e. Continued<br><br>(2) As the replacement occurs, the operations and human resources in the state hospital should be supported and enhanced to ensure safety, and the clinical programming should effectively support recovery.<br><br>(3) The capacity and network of community support services should be expanded to meet patient needs in a clinically appropriate manner consistent with system values.<br><br>(b) When the general assembly is not in session, the department of health shall seek and receive approval from the mental health oversight committee on specific programmatic recommendations, plans, or implementation steps to achieve the principles in the May 31, 2005 draft report prior to implementation. The mental health oversight committee shall approve or deny the recommendations and steps within two weeks of submission and shall oversee the implementation of the restructuring of the delivery of mental health services currently received in the Vermont state hospital.<br><br>(c) The commissioner of health shall report to the mental health oversight committee upon request in order to meet the requirements of this section. | **$625,000 B&GS** for preliminary design work for a new hospital facility<br><br>**$1,857,421 MH** for half year of operating sub acute rehabilitation program<br><br>**$588,278 MH** for half year of operating secure residential program |
| **July 12, 2005** | **Mental Health Legislative Oversight Committee**<br>VSH Futures Strategic Implementation Plan draft 2 presented | |

| Time Line | Actions | Appropriation |
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| **August 23, 2005** | **Mental Health Legislative Oversight Committee approves B&GS "New Inpatient Capacity Spending Plan"**<br>1. $50,000 to assist in site(s) selection and obtain site information to analyze opportunities and constraints with the various sites under consideration<br>2. $50,000 to develop design and space needs for the patients, the associated treatment programs and staffing requirements, including site infrastructure requirements.<br>3. $150,000 to produce schematic designs that address the space needs and site requirements for review and approval | **Permission to spend $250,000 of B&GS appropriation** |
| **November 2005** | **Futures Advisory Committee recommends:**<br>1. Creation of a primary inpatient program, preferably with FAHC.<br>2. Develop 1 or 2 smaller capacities, with the same programmatic standards as the primary program, preferably with existing inpatient psychiatric services.<br>3. Support for proceeding with inpatient program development is contingent upon funding and implementation of the community capacities in Secretary Charlie Smith's recommendations to the legislature | |
| **January 2006** | **Governor's Recommended Budget (for FY 07)**<br>1. Staffing to oversee Futures project implementation (2 FTE plus contract services)<br>Implementation goals:<br>a new, state-of – the- art psychiatric inpatient facility with a hospital partner designed to provide active treatment for the most acute and clinically complex patients;<br>new community residential and rehabilitation programs designed to serve patients who do not require inpatient care thereby focusing the role of the new hospital on inpatient treatment;<br>expand the capacity and network of community programs including a state-wide care management system | Futures Project Staffing:<br>**$105,000** |
| **January 2006**<br>Annualize program operations | **Governor's Recommended Budget FY 07 (continued)**<br>2. Recovery Residential programs (sub-acute and secure)<br>Programs designed to meet the needs of a longer-term care population currently served at VSH but who do not need inpatient-level care (*sub-acute rehabilitation service* capacity of 16-20 and *secure residential treatment* capacity of 6) | **$2,010,364** |
| Implemented in phases, beginning calendar 2007 | 3. Community Based Hospital Diversion Support (4 beds)<br>In geographically dispersed locations to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization.<br>This supports 4 of the 10 recommended by C. Smith | **$87,646** |
| Beginning February, 2007 | 4. Peer Support Services<br>The plan proposes to create new peer support programs targeted to individuals who use VSH. | **$79,961** |
| Beginning July 2006 | 5. Staff-Secure Transportation for Involuntary Adult Admissions<br>As an alternative to sheriff transport – this is a legislative requirement | **$67,032** |
| | 6. Care Management System:<br>To ensure that the system can manage and coordinate access to high - | **$161,112** |

| Time Line | Actions | Appropriation |
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| | intensity services so that Vermonters have access to the appropriate level of care. | |
| **January 2006** | **Governor's Recommended Budget FY 07 (continued)**<br>7. Planning, Design, Permitting new inpatient facility<br>The first phase of work approved by the MH Legislative Oversight Committee on August 23, 2005 will be completed this May. The second phase of work requires detailed site-specific architectural designs, floor plan schematics, construction engineering, and permitting. These costs are necessary to support the development of a new facility at any site. | **$1.350,000 B&GS** |

# APPENDIX D

## Additional Futures Project
## Materials Available Upon Request